State of Maryland / Department of Health and Mental Hygiene

04501

AM

							· , ·	Ce	rtifica	te of	Death		Reg. No.		9 7 6	0 1
		Physicia /Medic		Decedent's Name (First, Middle, Last) ROSA A. JENNINGS							2. Date of D Month JAN		o'd'o	3. Time o	of Death	
-	7	Examir			(If not institution, give)				4b. City, Town, or Silver	Sprin	g MON	TGOM	ERY	
		Funeral Director		5. Social Security 578-32-	1164	7. Ag	ge (In yrs. le 86	est birthday Yrs.) If Unde Months	Days	If Under 24 Hrs Hours Min	8. Date of E (Month, L Jan.	26,1914	9. Birthp Court Wa	lace (Stata try). Sh.	or Foreign DC
		anyland show dat	Director	Usual Residence of 10a. State	10b. County		10c. City, Town or Location				_			1	0d. Inside (Olty Limits
		ath with the Marylan 23a or 28a-f show		MD 10e. Street and Nu	Montgo umber 2nd Aven		Silver Spring 10f. Zip Code 20910					What Cour	Country?			
	50	within 72 hours after designe.	Funeral	11. Marital Status 1 ☐ Never Mar	12. Was Decedent Armed Forces' 1 Yes 2	nt Ever in U,S. 13. Was Deceder s? If Yes, specify		dent of I	ent of Hispanic Origin? (Spacify Yes ify Cuban, Mexicen, Puerto Rican, et- X No Specify:		U.S.A. Yes or No- (es or No- (etc.) 14. Raca - Americ Black, White, Specify: Bla		etc.			
, OO	15-00		ieted by		4 ☐ Divorced 15. Decadent's Educify only highest great	le completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)			16b Kind of Business/inc						
	Maryland 21215-0020		e Completed	Elementary/Sec	ondary (0-12) (First, Middle, Lest)	Collaga (1-4or 2 yrs	5+)				Supervi 18. Mother's Na		Government			
	rylan	should be nd Mental marked o	To Be		ace Tole			10h Mai	ling Address	e (Simo	Ma:	_	William		Corlo)	
		permit. Pages 1 and 2 should be filled be permant of health and Mental Hygic important: if item 27 is marked other any injury or other traumatic event, gonce.		Sylvia	B. Mill			r)	8802	2nd	d Ave.,	Silve	r Sprin	g, M	ID 20	910
b	altimore,				sposition ! □ Cremation 3 □ I 5 □ Other (Specify,				osition (Nematory or		Park	Date 2/1/20	20c. Location		el, M	.D
	Ball			21. Sign and of Funeral Sarvice Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850												
		Physician		23a. Part1. Enter shock, or he	the disease, or comp alt failure. List only o	fications that cause one cause on each I	d the death	. Do not e					arrast,		Approxima Interval Be Onsat and	etween
-	1	/Medical Examiner		Immediate Cause disease or conditi resulting in death)	on	a.			nor					0	mec	lay
	7	and -transit	Examiner	Sequentially list of	onditions,	b	Due to (or	as a cons	equence of)):				+		
	68760,	rificate be executed ng physicien and s as the buriel-transit	edicai Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
	Box 6	death certifi e attending p ed for use as	ian/Me			d										
	P.O.	requires that the deal sen signed by the att hould be detached fo	by Physician/M												of deeth?	
	Division of Vital Records,	aw Is b	Completed b								24a. Wa	as an autopsy rformad?	av	ere autopsy allable prior impletion of death?	to	
	al Re	The ate h	e Com	25. Was case refe									Yes Sta	1 (⊒Yes 2€	3 No
	Į Š		To Be	examiner?	_	Hospital:	ient 2 🗆 I	ER/Outpati	ent 3□ D	OA Ot	26. Place of De her: 4 ☐ Nursing	eath <i>(Check only</i> Home 5 Ra		her (Specia	(y)	
	sion o	After After fune	ertification: 7	P⊡Natural 2 ☐ Accident	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b.					28c. Inju	ryat ork?]Yes 2 □ No		e how injury occu			
	Divis	at or Attendests after deat	Sertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rurel Route Number, City or Town, State)				m <i>ber</i> ,

29b. Signature and title of cart

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Yaar)

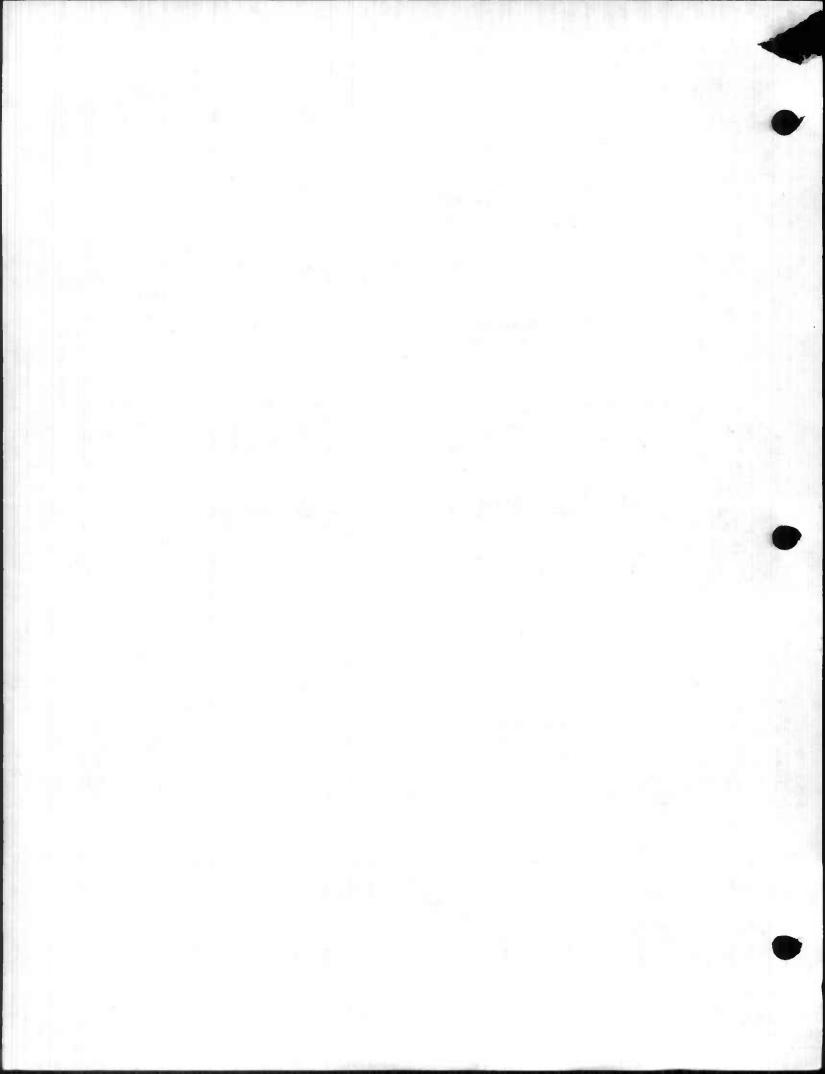
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10801 Lockward DR Sil. SPR MD 20901 INDRISANO 32. Registrar's Signature

State Registrar 29a. Certifier (Check only one)



An			Plea END IAMEND#I9 2/8/2000,BMW,MO		Print In PER of Maryla		delible International ANT G7 artificate of		All Coples 2000 Mental Hy	Are Leg	ible.		
			1. Decedent's Name (First, Midd						2. Date of De	eath	3. Time of Dec		
	Physici /Medi		Kathryn Sincla	ire Jills	son				Januar	y 30, 2	000 9:00Al		
	Examir		4e Facility Neme (If not institution	n, give street and n	umber)			4b. City, Town, o	or Location of Deat	-	y of Death		
			Manor Care-Bet	hesda				Betheso		Montg	omery		
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 F	7. Age (In yr.	s. last birthday)	Months Days		in. (Month, D	rth ay, Year)	9. Birthplace (State or Fo		
	Director		579-34-3578	ILIM 263 F	89	Yrs.			May 8,	1910	New York		
	P		Usual Residence of Decedent 10a. Stete 10b. County	ocation				10d. Inside City Li					
	the Marylan 28a-f ahow notified at	ō	Maryland Montg	omerv	Re	ethesda					1 ☐ Yes 2X		
	28a-f	rec	10e. Street and Number	omery	Бе	chesua	10f. Zip Code			10g. Citizen of	What Country?		
	23a or	<u>=</u>	6530 Democracy		2081	7		United	States				
	9 5	Funeral Director	11. Marital Status	12. Wes Dec	cedent Ever in	U,S. 13.			(Specify Yes or Ne erto Rican, etc.)		lace - American Indian,		
0	72 hours after netural', or He		1 Never Merried 2 Mer	Armed F ried 1 Ves If Yes, G	2 2 No		il Yes, specify Cui		erro Hican, etc.)		eck, White, etc.		
00	ours Fair,	1 by	3 X Widowed 4 □ Divorced	Yeer or I	Detes:		TEL TOS ZESTNO	эреспу.		Speci	Specify: White		
5	n 72 hours natural',	Completed	15. Deceder (Specify only highe	it's Education st grade completed)	16a. Dece	dent's Usual Occu	work done during most of working			Business/Industry		
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	TO 100 to 100		12 17. Father's Name (First, Middle,	/ net)		Libi	rarian	19 Mathada N	eme (First, Middle		orary		
Maryland	ould be f Mental I arked of atic eve	Be		Lasij							me)		
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ē,	Health Health Herm 27		20e. Method of Disposition	occoct and/	Daughter 20b.	. Place of Dispo	sition (Name of		Date	Maryla 20c. Location			
no	permit. Pages 1 and Department of Health Important: If Nem 27 any Injury or other to once.		1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 21. Structure of Ferd Service Licensee Approximate of Ferd Service Licensee Cremetory or other place) Feb 1 Montgomery Crematorium, Inc. 2000 Bethesda, Maryland Properties Prop										
Baltimore,	Department Department Important: I any injury o												
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			23a. Part1. Enter the disease, or	complications that	caused the de				Marylandiac or respiratory		4-3501 Approximate		
8	Physician		shock, or heart feilure. List	only one cause on	eech iine.						Interval Between Onset and Deal		
	/Medical		Immediete Cause (Final diseese or condition	Del	hydrati	On					1		
	Examiner		resulting in death)	ө	-	(or as a consec	quence of):						
	D #	ner		A1:	zheimer	's Deme	entia						
	an and inal-transit	Examiner	Sequentially list conditions, if any, leading to immediate										
60,	cian i												
9289	physic the	D	thet initieted events resulting in death) Last		Due to	(or as a conseq	uence of):						
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Box	death e atter ed for u	clar	Dadii Oharda Maraka a din						1 001 011	4.1			
0	the the	hys	Pert II. Other algolificant condition	ons contributing to d	leath but not re	esulling in the u	nderlying cause g	iven in Pert I.		Yes ZENo	ontribute to the cause of do		
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Records,	.= 07 73	8							24a. Wa	an autopsy	24b. Were autopsy lindi		
00	20 00	plet							pen -	ormed?	available prior to completion of caus of death?		
Ĭ	The law ate has page 2	Completed							10	Yes 2 No	1 ☐ Yes 2 ☒ No		
Vital	certificate rector, pag	0	25. Wes case referred to medica	i				26 Place of D	eeth (Check only		12.103 22.10		
>		To B	examiner? 1 ☐ Yes 2 ☑ No	Hospitel:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA O	ther	Home 5 ☐ Res		her (Specify)		
ot	g Physer this nerel di		27. Menner of Deeth	28a. Dete		28b. Time o				how injury occu			
0	Attending For death.	atio	1 Neturel 5 Pendir 2 Accident Investi	'M	mi, Day routy	injuly		Yes 2 No					
Division	or Attendes after deat	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 288. Plac	e of Injury - At ling, etc. (Spec	home, ferm, str city)	reet, factory, office		28f. Location City or To	(Street and Num wn, Stete)	ber or Rural Route Number,		
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the Iuneral	edical	29e. Certifier (Check only one) Certifyir 2 Medical	g Physician: To the Examiner: On the b	e best of my kr pasis of examination stated.	nowledge, death nation and/or in	n occurred et the t vestigation, in my	ime, date and pla opinion, deeth oc	ce, and due to the curred et the time	cause(s) and m date and place	nanner as stated. , and due to the cause(s)		
	within 2 To the comple	ž	29b. Signeture and title of certifie				29c. Licen	se number	T	29d. Date sign	ed (Month, Day, Year)		
	-) line	(Muly)	1-3		บร	1280		January	31, 2000		
	>		30. Neme and address of person	who completed cau	se of death (tte	em 23a) (Type,		1200		January	JI, 2000		
			Anushirvan Doc	lgar, M.D.	1321	9 Execu	tive Par	k Terrac	e, Germa	ntown.	Maryland 208		
	Sta	_	31. Date liled (Month, Day, Year)		Registrar's Sign	nature	Soon						
	Reaistr	ar	EED O	2000	renewa	- D.	acon	·V					



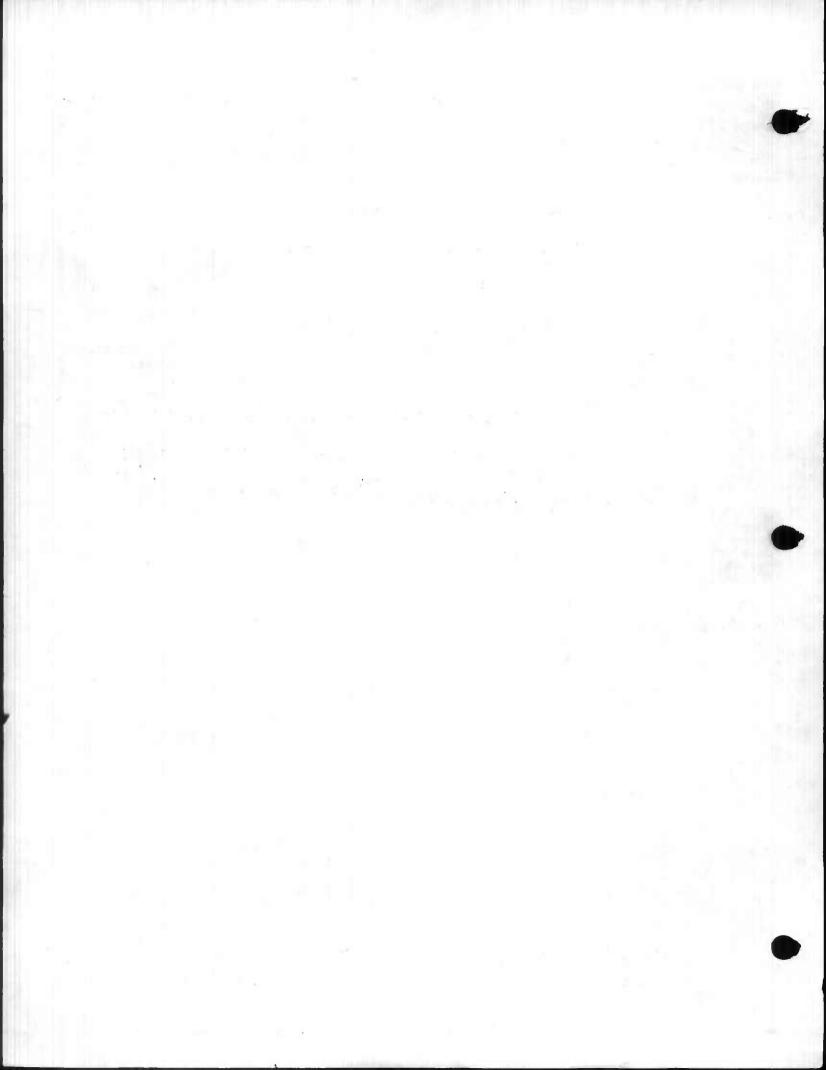
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dale of Death 3. Tima of Death Day Month **Physician** 31, RAYMOND JAN. 2000 L. JOHNSON 1:20 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Lorian Nursing Home HOWARD Columbia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10XM 2□ F 55 Yrs. 215-40-3645 Maryland July26, 1944 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1Deyes 201No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7934 Harriett Tubman Lane U.S.A. 21044 death v Funerai 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? e filed within 72 hours after de li Hyglene.
other than *natural*, or item 1 Yes XXNo
If Yes, Give
Year or Dates: Never Married 2 Married aitimore, Maryland 21215-0020 Black 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Construction Laborer 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Nem 27 Is marked ofth eny Injury or other treumatic avant pages. 17. Father's Neme (First, Middle, Last) Be Raymond Johnson Florence Kellv 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 t9a. Informant's Name/Relationship (Type, Print) 7941 Harriett Tubman Ln., Columbia, MD Florence Harris (Mother) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Slete 20a. Method of Disposition cemetery, cremetory or other place) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 2/4/00 Columbia, MD 4 ☐ Donation 5 ☐ Other (Specify) Locust Cemetery Signeture of Funeral Service License 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 ROCKVILLE, MD 20850

Tons thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bause on each line. 23a. Pert1. Enter the discrete, or conshock, or heart feilure. List only Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final 3montas. disease or condition resulting in death) Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Was en autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No certificata Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) axaminer?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 T Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) manner steled. 29b. Signature/and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) Feb 02,2000 1. M. 1849 Lace PATRIKENT PKWY 11055 LITTLE 30. Name and address of person who completed cause of death (Item 23s) (Type, Print) SCHAEGER , JR EDWIARD CorumBiA, w. MD. 31. Date filed (Month, Day, Year) 32. Dog strar's Signature State FEB 03 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Alvin I KAY, MD 12 AM 2000 2 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Months Days 10 M 20 F 83 Yrs. WASTINGTON, D. 216-40-8526 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X) Yes 2 No MONTGOMERY **POTOMAC** MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 9035 CONGRESSIONAL PARKWAY U. S. A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: WW2 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 Never Married 2 Merried WHITE 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) PHYSICIAN MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROSE KAMINSKY MAX L. KAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 19a. Informant's Neme/Relationship (Type, Pnint) 9035 CONGRESSIONAL PARKWAY, POTOMAC, MARYLAND ELAINE B. KAY - WIFE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2/OfCremation 3 ☐ Removal from State MOUNT COMFORT CREMATORY 2/3/2000 ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) Cardiogenic Due to (or es e consequence of): Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initialed events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Myelodysplastic Syndrome 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Chronic Obstructive Lung Disease 1 ☐ Yes 2 Ø No 1 Yes 2 No 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide

12mu signed by director. Kay, Alvin this After death. filled in by the Director

Physician

/Medicai

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Experience must be notified at 2008.

Physician /Medical

Examiner

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Maryland

Baltimore,

25. Was case referred to medical exeminer? 1 Yes 2 No 27. Manner of Death

4 Homicide

29a, Certifier

6 Could not be determined

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

12 Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number

29b. Signamen and title of cartifier

D0026459

29d. Dete signed (Month, Day, Year)

eddress of person who completed cause of deeth (Item 23a) (Type, Print) 5530 WISCONSIN AVE # 800 Chey Char, MP 20815 LERNER MO

Steven D. 31. Date filed (Month, Day, Year) FEB 04 2000

32. Registrer's Signature

State Registrar

To the Hospital within 24 hours or To the Funeral Completely filled

12

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** January 28, 2000 Rose Carmen Kingsbury 4:25 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill-Bethesda Bethesda Montgomery HUnder 24 Hrs. 8. Data of Birth (Month, Day, Year)
June 22, 1900 If Under 1 Year Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗓 F 99 New York Yrs. 155-36-1649 Director Usual Rasidence of Decedant with the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "natural", or items 23a or the Medical Examiner must be 20814 5215 Cedar Lane United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 White 1 ☐ Yes 2 🖸 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16h Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: if Ilem 27 is marked othe any Injury or other tra 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Fathar's Name (First, Middla, Last) Be Filomena Greco Frank Abarno 10 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routs Number, City or Town, State, Zip Code) 20016 David W. Kingsbury/Son 4000 Cathedral Avenue, N.W., #501B, Washington D.C. 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata Data 20a. Mathod of Disposition cematary, crematory or other place) 31 Jan. 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from State Bethesda, Maryland Montgomery Crematorium, Inc. 2000 4 ☐ Donation 5 ☐ Othar (Specify) 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funaral Sarvice License M00672 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Finel Respiratory Failure disease or condition rasulting in daath) Examiner Due to (or as a consequence of). Examiner Organic Brain Syndrome The law requires that the death certificate be axecuted physician and s the burial-trans Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in daath) Last Due to (or as e consequence of) Box 68760 Physician/Medical Dua to (or as a consequence of) for use as P.0. Part It. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 | Yes 2 | No 3 | Probably 4 | Unknown signed b Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Completed peeu page 2 1 ☐ Yas 2 ☒ No 1 Tyas 2 No certificate Division of Vital Physician: director, Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitat: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yas 2 No Certification: To this After thi 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Tima of he Hospital or Attending Pin 24 hours after death.

The Funeral Director: After the pletely filled in by the funara 5 Pending invastigation 1 ☑Natural 2 ☐ Accidant 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicida 28a. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homtcida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and menner stated. 29e. Cartifier Medical within 24 ho To the Fune completely f (Check only one) \$ 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number 2

State Registrar Homes

Thomas Joseph, M.D. 31. Data filed (Month, Day, Year)

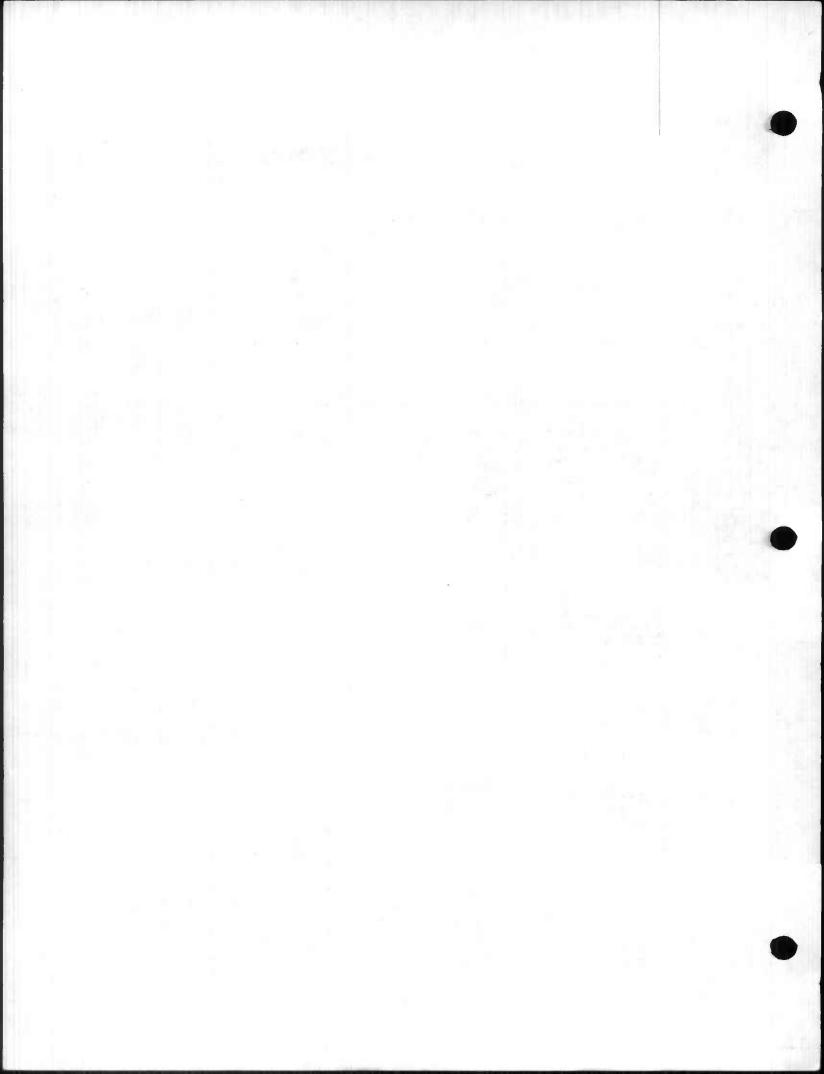
30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

2000

32. Registrar's Signatura

001

50 West Edmonston Drive, #207, Rockville, MD 20852



Physician /Medical Examiner

Funeral Director

Pages 1 end 2 should be filed within 72 hours after death with the Maryland

Department of Heelth and Mental Hygiene.
Important: if item 27 is merked other than "natural", or items 23s or 25s-f show any injury or other traumatic event, if a Medical Example must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

The law requires that the deeth certificate be executed ettending physician end for use es the burial-tran Division of Vital Records, P.O. Box 68760, sate has been signed by the page 2 should be detached certificate has

within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director, To the Hospital or Atlanding Physician: 12 Be Completed by Funeral Director Medical Certification: To Be Completed by Physician/Medical Examiner

ELEMER				K	122			JAN.	30,	2000		10:33 AM
4a Facility Name (If not institution	, give street and nur	mber)			4b.	City, Town, or	Location of De	eath	4c. County	of Death	
5520 Fri	lendshi	p Blvd. #	2016N			C	hevy C	hase		Montg	gomer;	У
5. Social Security			7. Aga (In yrs.	last birthday)	If Under 1		Undar 24 Hr		Birth		9. Birthpl	lace (State or Foreign
215-38-4 Usual Residence of		1 X) M 2□ F	90	Yrs.	Months [Days	Hours Min	Sep.	28,	1909	Hunga	ary
10a. Stata	10b. County		10c. Cit	y, Town or Lo	ocation						10	Dd. Inside City Limits
Md.	Montg	omery	Ch	evy Ch	ase							1 Tes 2 No
10e. Street and Nu	mber				10f. Zip Co	ode			10g.	Citizen of W	Vhat Coun	try?
5520 Eri	iandehi	p Blvd. #	2016N		2.0	815				U.S.A	١.	
11. Marital Status	Lendonia	12. Was Dece	dant Evar in U	S. 13.			anic Origin? (Specify Yes or rto Rican, etc.)	No-		e - America	
1 Never Mari		Armed Fo led 1 ☐ Yas If Yes, Giv Yaar or Di	2 No		1 Yas, specify	_		no Rican, etc.)		Specify	k, White, e	ite
	15. Deceden	's Education		16a. Dece	dent's Usual (Occupation	n		168	o. Kind of Bu	siness/Ind	lustry
		st grade completed)	40.5.)	(Give	kind of work DO NOT use	done dun retired)	ng most of w	orking				
Elementary/Seco	ondary (U-12)	College (1	-401 3+J		Banker					Ва	ankin	g
17. Father's Name	(First, Middle,	Last)				16	. Mother's Na	ame (First, Mid	die, Mai	den Sumam	10)	
Elemer	Kiss						Margi	t Horva	ath			
19a. Informant's N Edith		hlp (Type, Print) er – Daug	hter	19b. Maili 1341	ng Address (8 .5 Shak	Street and	Number or F	Rural Route Nu	mber, C	ity or Town, velanc	State, Zip	Code) 44120
20a. Method of Dis	position		20b. F	Place of Dispo	osition (Name	of		Date	200	c. Location -	City or To	wn, State
1 🗆 Burial 2	Cramation	3 Removal fmm	State		matory or other			12///201	NO F	-11- (24	h Wa
	5 Other (S		Na		Crema			2/4/200				
21. Signature of Fi	uneral Service	Licensee						oseph (. 20016
23a. Part1. Enter shock, or hea	the diseasa, or art failure. List	complications that conly one cause on e	aused the deat ach line.	h. Do not en	ter the mode	of dying,	such as cardi	ec or respirato	y arrest			Approximate Interval Between Onsat and Death
Immediate Cause disaase or condition	òn	. Ce	rebrova	ascula	r Acci	dent]	0 days
resulting in death)		u	Due to (d	or as a conse	quence of):							
		ь. Ну	perten	sion							1 3	years
Sequentially list co	onditions,	0		or as a conse	quence of):							
i ceuse. Enter Und	ariving	At	herosc	lerosi	S						3	years
Cause (Disease of that Initiated event resulting in death)	s Last	0	Dua to (c	r as a consec	quence of):							
		d									1	
											1	
Part It. Other signi	ficant condition	ens contributing to de	eath but not res	ulting in the u	inderlying cau	nevig eau	in Pert I.					the cause of death
									☐ Yee	2□ No	3X Prot	bably 4 Unknow
								04- 1	V		24h W/	ere autopsy tindings
								24a. y	vas an a erforme	d?	ava	ailable prior to mpletion of causa
											of	death?
								1	☐ Yes	2 K) No	1.	Yes 2□ No
25. Was case refe exeminer?	rred to medica						6. Place of D	eath (Check or	nly one)			
	[No	Hospital: 1 🔲	npatient 2	ER/Outpatie	nt 3D DOA	Other:	4 Nursing	Home 5X F	Residenc	a 6 DOth	er (Specifi	y)
27. Manner ot Dea 1 \\ \X\ Natural 2 \subseteq Accident	th 5 Pendir investi		of Injury th, Day Year)	28b. Time of Injury	of 280	c. tnjury a Work? 1 □ Ye	s 2 No	28d. Descr	ibe how	injury occur	red	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	not be Ined 28a. Place buildi	of Injury - At h	ome, farm, st	raat, factory,	offica		28f. Location City or	on (Stree Town, S	et and Numb State)	er or Rura	I Routs Number,
29a. Certifier (Check only one)		g Physician: To the Examiner: On the ba										
29b. Signature and	d title of cartifie		1	^	29c. I	Licanse n	umber		29d	. Date signe	d (Month,	Day, Year)

D31319

8218 Wisconsin Ave. Bethesda, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

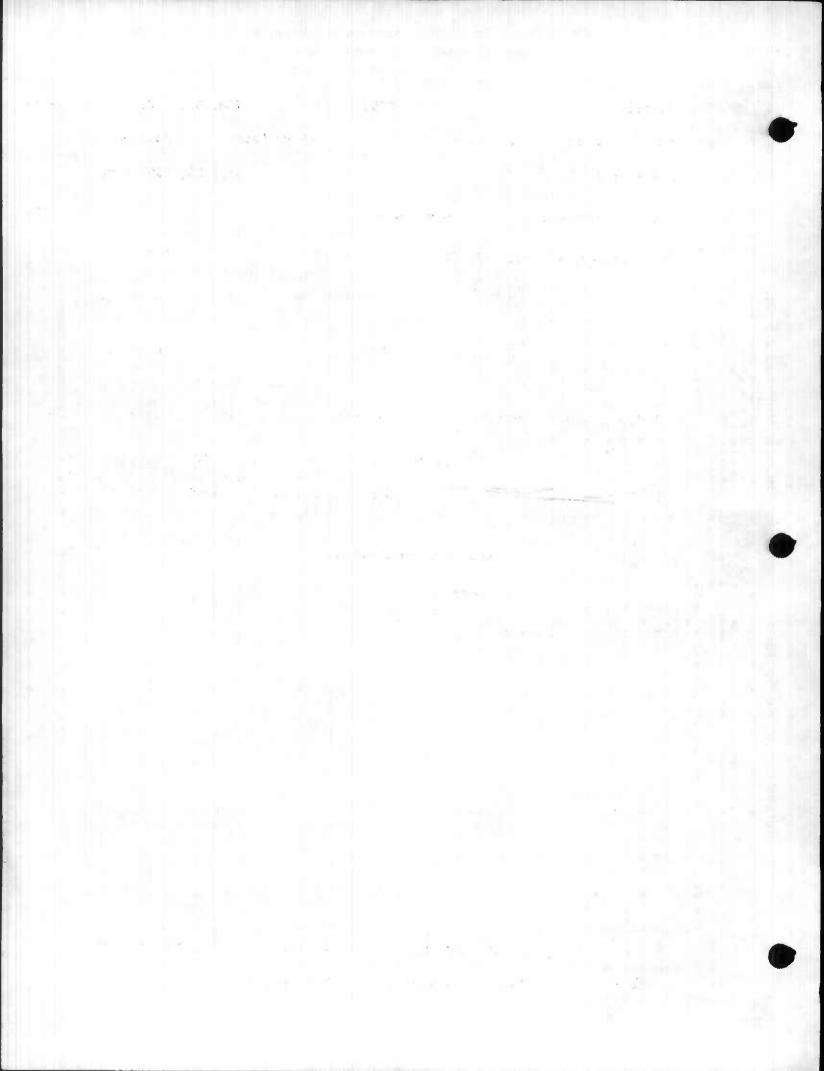
Albiol, MD.,

Feb. 1, 2000

State Registrar

Loreto S.

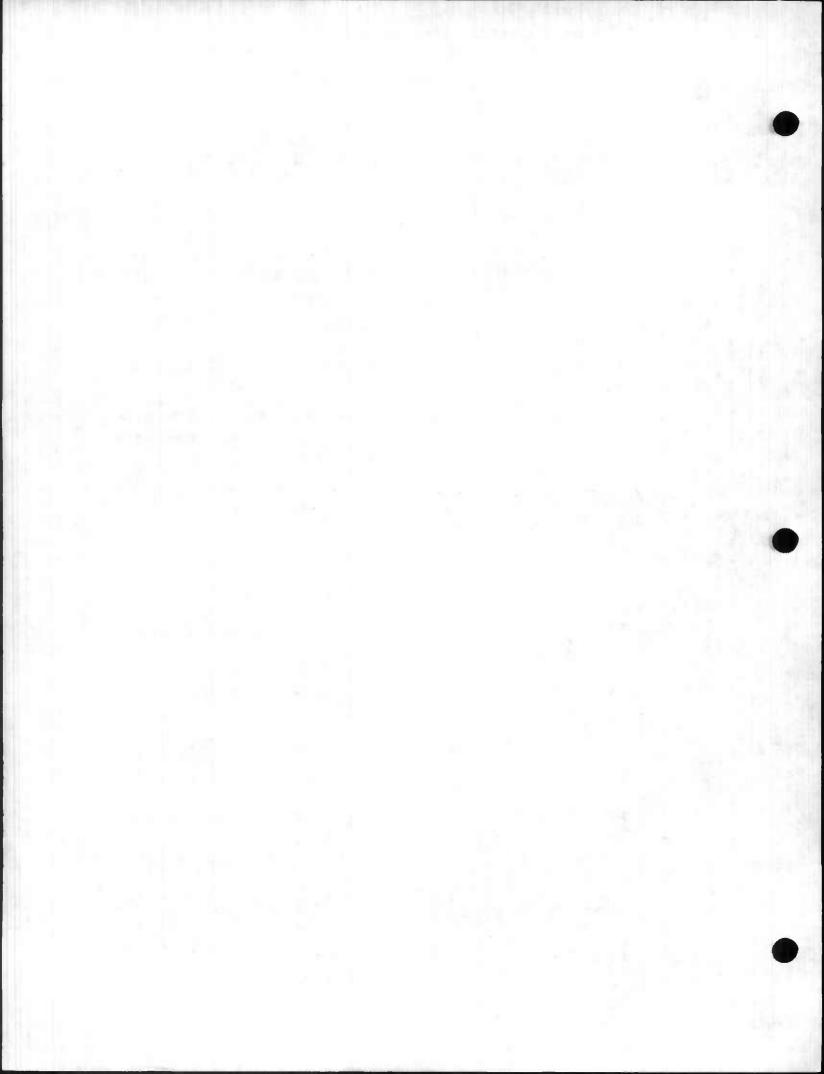
31. Date filed (Month, Day, Year) FEB 04



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certific	ate of	Death		Reg. No.			
D	1. Decedent's Name (First, Middle, Last)					2. Date of I Month	Death Day	Year	3. Time of Death	
Physician /Medical	BERTHA MARIE K				Janua			3:00 PM		
Examiner	4a Facility Name (If not institution, give street and n 7926 Gas House Pike	um <i>ber)</i>			Fred	m, or Location of De erick		nty of Death lerick		
Funeral Director	5. Sociel Security Number 217–30–6764 6. Sex 1 M 2 F	7. Age (In yrs. last bir	Mont	hs Days			8. Date of Birth (Monty, Day, Year) March 10, 1935 Maryland			
r 28a-f show Inotified at frector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1 Maryland Frederick Frederick									
ms 23s or 28s-f show r must be notified at neral Director	10e. Sireef and Number 7926 Gas House Pike	Frede		Zip Code	1			10g. Citizen of What Country? U.S.A.		
natural', or tems 23s or 28s-fe fical Example must be notfled sted by Funeral Director	11. Marital Status 1 Never Merried 2 Merried 1 Never Merried 2 Merried 1 Yes, Year or	24 No	13. Was Decedent of Hispenic Origin? (Spill Yes, specify Cuben, Mexican, Puerto			in? (Specify Yes or Puerto Rican, etc.)	pecify Yes or No- p Rican, etc.) 14. Race - Black, Specify:		American Indian, White, etc. White	
- 3	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College		16a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)		of working	orking		f Business/Industry		
omp	11	(1-401 547)	Fa	rmer			Dai	iry Fa	rming	
and Mentel Hygiene. marked other than iumatic event, the M. To Be Comp	17. Father's Name (First, Middle, Last) Elmer Norris Windsor					's Neme <i>(First, Midd</i> Jane Simm	e (First, Middle, Maiden Sumame) e Simmons			
	19a. Informant's Name/Reletionship (Type, Print) Robert R. Kisner (Husba		ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) House Pike, Frederick, Maryland 21701							
S = 5	20a. Method of Disposition 1									
nysician Medical xaminer	23e. Part 1. Exper the diagram are complications that shock, or near fattle. Let only one bause on Immediate Cause (Final disease or condition resulting in deeth)	Due to (or as a	1201	NORT mode of dy	H MARK ing, such as o	Y & SON F ET ST., F ardiac or respiratory	REDERICE			
e attending physician and by for use as the burial-transit is claryMedical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	Due to (or as a c								
d for u	Part II. Other significant conditions contributing to	death but not reculting in	the underlyi	00 001100 0	iven in Part I	23h D	3b. Did tobacco use contribute to the cause of death			
d by the	Partition of the regulations contributing to	death but not resuming in	i the underlyi	ng cause g	Went in Francis.		☐ Yes 2☐ No	\ /		
2 N D								av.	ere autopsy finding allable prior to mpletion of cause death?	
page page						11	Yes 25 Mo	10	Yes 2□ No	
Set or Be	25. Was case referred to medical axaminer?			To		oi Death (Check on	ly one)			
F Sign		Inpatient 2 ER/Ou		DOA			esidenca 6 🗆 (-	y)	
Affect Form	2 Accident investigation	onth, Day Year)	rm. street, fa		Yes 2 N	No.	scribe how injury occurred ation (Street and Number or Rural Route Number,			
	29a. Certifier 1 Certifying Physician: To the	ca of Injury - At home, Ia ding, etc. (Specify) ne best of my knowledge	, death occur	red at the	ime, date end	I piece, end due to t	Town, State) he ceuse(s) and	menner as s	tated.	
he Funer pletely fill edical	(Check only one) 2 Medical Examiner: On the and me	basis of examination an inner stated.	d/or Investiga	tion, in my	opinion, deat	n occurred at the tim				
To the comple	29b. Signeture and title of cartifier			1	3/0 J	-9	29d. Date slg	ned (Month,	Day, Year)	
		boro Medica		er,	Voodsbo	oro, Mary	land 217	98		
State	31. Dete filed (Month, Day, Year) 32.	Registrar's Signature	. / A			_				

DHMH 16 Rav 6/95



Piease Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January ²25, 2000 Edmond Kent 8:00 P.M. 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Deut Year) 9. Birthplace (State of Warch 10, 1925 Wisconsin If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1₩ M 2□ F 393-22-7946 74 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 146 Kline Blvd. 21701 U.S.A. 12. Was Decedent Ever in U.S. Amed Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U. S. Government Elementery/Secondary (0-12) College (1-4or 5+) Historian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leslie Kent Elsie Ingraham 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alana Diane Glover/Daughter 1711 Derrs Square West, Frederick, Md. 21701 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Resthaven Memorial Gardens Jan. 1 Surial 2 □ Cremation 3 □ Removal from State 28, 2000 Frederick, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Keeney & Basford Funeral Home 106 East Church Street, Frederick, Md. 21701 M00021 23a. Part T. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heef feiture. List only one cause on each line. Approximate Interval Between Onset and Death 3 day. nemmino dan Due to (or as a consequence of) (0101) Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? liver metastassos with 1) Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: 1 (Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

The law requires that the death certificate be execu

signed by the i

cate has l

certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stelly filled in by the funeral director; g

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Be Completed

Medical Certification: To

Box 68760.

P.O. 1

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after

I Hygiene.

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked other any liqury or other traumatic event abbs.

Saltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

10a, Street and Number

11 Marital Status

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Physician/Medical þ

Immediate Cause (Final disease or condition resulting in death)

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

5 Pending investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29e. Certifler

1 Natural
2 Accident

3 Suicide

4 Homloide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and litle of certifier

29c. License number D18063

29d. Date signed (Month, Day, Year) January 27, 2000

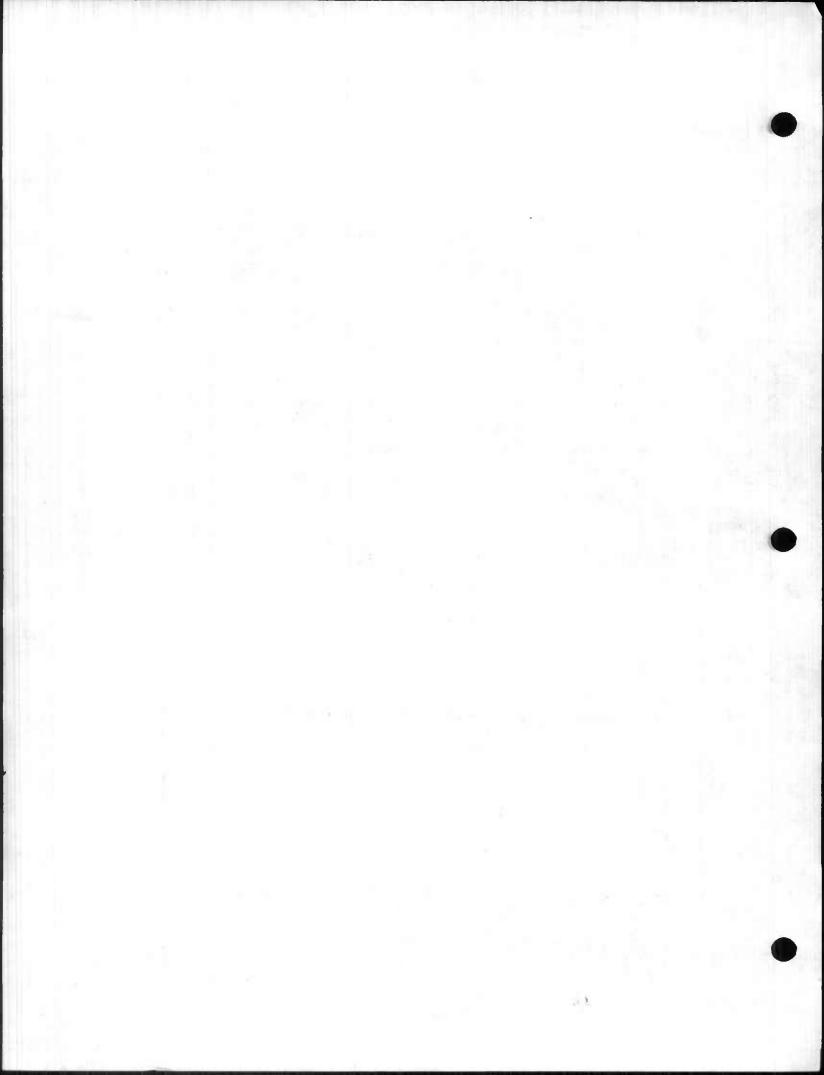
and address of person who completed cause of death (Hem 23a) (Type, Print)
Abdul Majeed, M.D., 801 Toll House Ave., Frederick, Md. 21701

State Registrar

DHMH 16 Ray 6/95

31. Date filed (Month, Day 2 8 2000 32. Registrar's Signature

b. Sparks



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

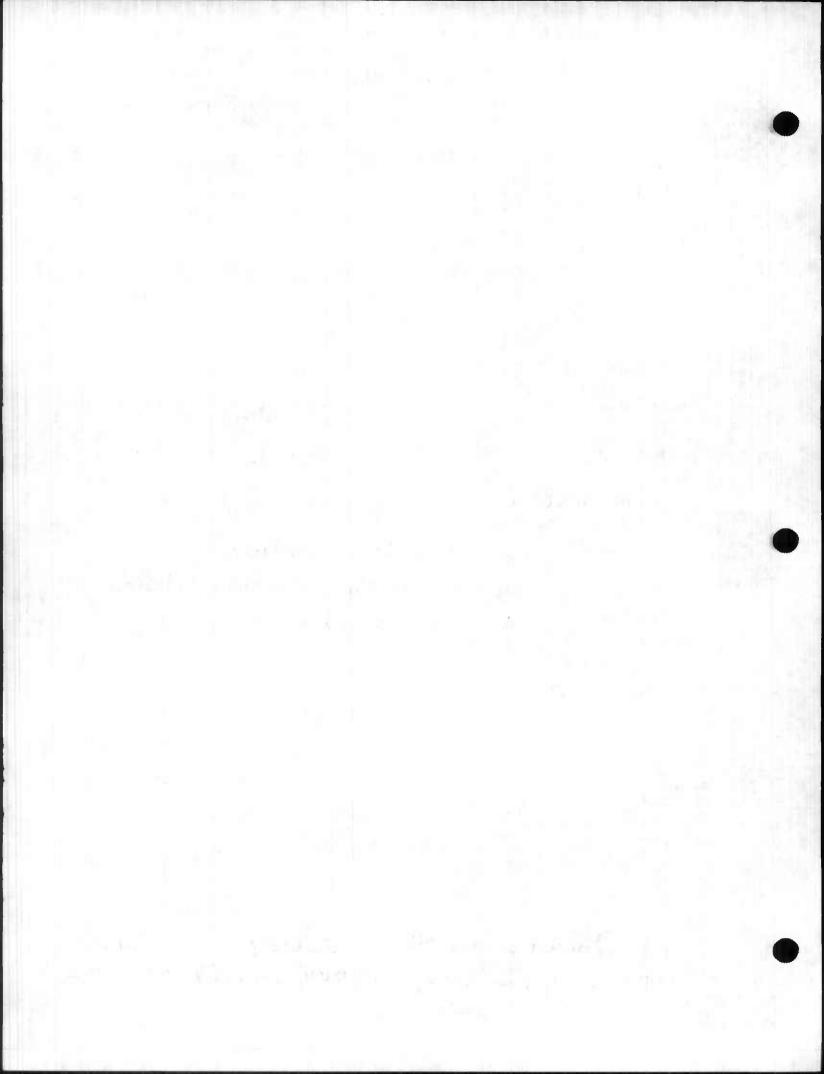
State of Maryland / Department of Health and Mental Hygiene | | 04509 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Corabel **Physician** Kean January 24, 2000 3:30 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital Hours Min. 8. Dete of Birth (Month, Dex Year) 9. Birthplace (State or Foreign March 20, 1914 On10 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year **Funeral** Months Deys 1□ M 20 F 280-24-3900 Director Usual Residence of Decedent 10a, Stafe 10b. County 10c. City, Town or Location 10d. Inside City Limits if Hypiene. other than "natural", or hame 23e or 25e-f smo-went, the Medical Exeminar must be notified at Yes 2 No Maryland Frederick Frederick Directo ä 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 355 Monteuve Lane 21702 Funeral filed within 72 hours after death 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 Never Merried 2 Merried Maryland 21215-0020 Specify:White 1 Yes 2 No Specify: þ 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Seamstress/Presser Clothing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 2 should be and Mental is merked Pear1 Sevey Bice Buie 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 spartment of Health as Important: If fem 27 is a any injury or other to once. 7338 Kemp Lane, Frederick, Maryland Mrs. Dorothy Blank, Daughter Baltimore, 20e. Method of Disposition
1 ÄBunel 2 ☐ Cremation 3 ☐ Removet from State 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Resthaven Memorial Gardens, Jan. 28, 2000 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Name and Address of Facility Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) **Examiner** Physiclan/Medical Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury Que to (or es a consequence of) Kneumenia P.O. Box 68760. the ettending physician fhat initiated evenfs resulting in death) Lasf Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? After this certificate has 1 Yes 2 No 1 □ Yes 2 □ No erel Director: After this certifical filled in by the funeral director, I l or Attending Physician: after death. Be 25. Was case referred to medice! 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA Medicai Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could nof be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and fitte of certifier sha Belani MD 1.24.2000 D26137 Frederick, MD-21702 30. Name and address of person who completed cause of death (Item 23a) (Type:Print) # 104, 198 Thomas Johnson Drive, Swite # 104,

Registrar

State

7 2000 Signature

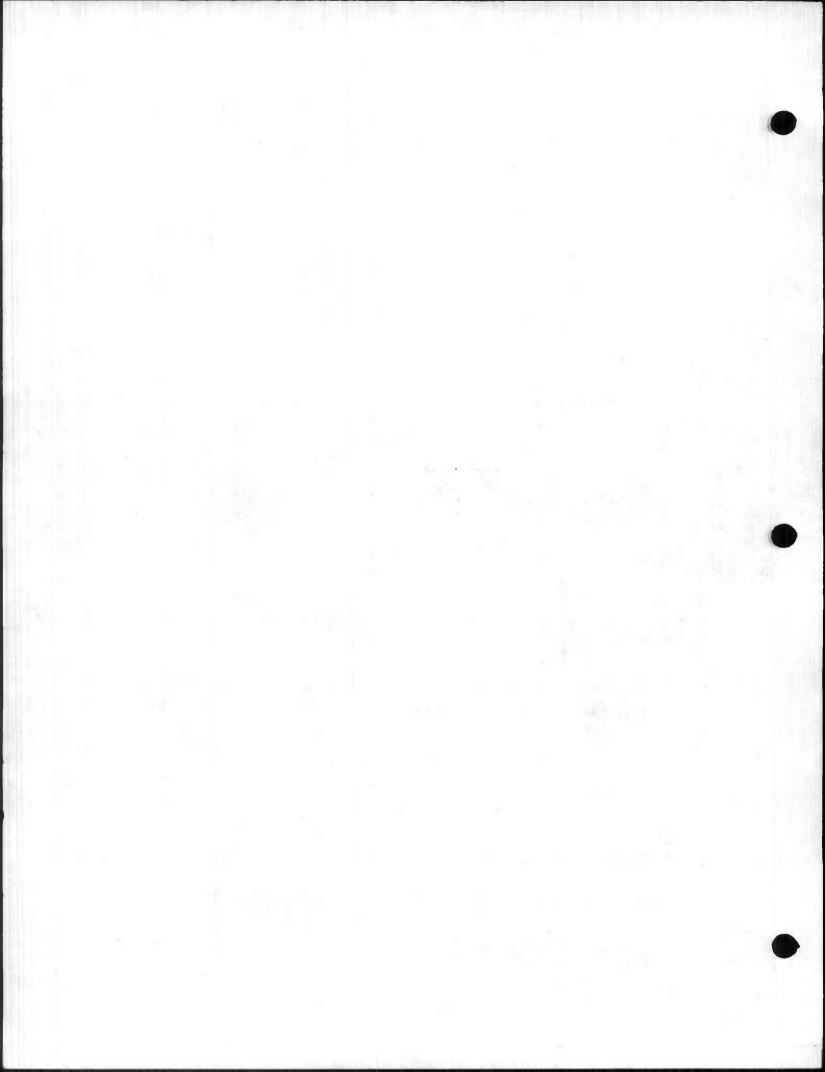


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State of Maryland / Department of Health and Mental Hygiene 0 0 1, 5 1 0

			Certificate of	Death	Reg. N	lo.	4010			
	Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last)						3. Time of Death			
Physician /Medical	JANET E.	K	KELLEY		Month Day Year January 23,2000 3:30pm					
Examiner	4e Facility Name (If not institution, give street as	nd number)		4b. City, Town, or Local	tion of Death 4	c. County of Death				
	Greater Baltimore	Medical Ce	nter	Towson		Baltimo	re			
Funeral Director	5. Social Security Number 214-36-1265 Usual Residence of Decedent	7. Age (In yrs. last bir	Yrs. Hunder 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Dete of Birth (Month, Day, Yea (arch 14,	9. Birthy Cour 1937 Mary	place (State or Foreign htry) Land			
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he Mary tas-f sh outled	Maryland Baltimore	Owi	ngs Mills				1□ Yas 20 No			
after death with the Maryland or Name 23a or 28a-1 show miner must be notified at 7 Funeral Director	10e. Street and Number 3000 Walnut Ave .		10f. Zip Code 211	17		Citizen of What Cou nited Sta				
F. F. D.	Arm 1 Never Married 2 Married 1 H	Decedent Ever in U,S. ed Forces? Yes 2 No s, Give r or Detes:	13. Was Decedent of it Yes, specify Cub	Hispanic Origin? (Specifican, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: Wh				
72 hg	15. Decedent's Education (Specify only highest grede comple	16a.	Decedent's Usuel Occu	pation during most of working	16b.	Kind of Business/In	dustry			
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Be setting	17. Father's Name (First, Middle, Last) Harold	McDevit	t	18. Mother's Neme (F	First, Middle, Maide	en Sumame) Etzle	r			
should marke umetic	19e. Informent's Neme/Reletionship (Type, Prin		. Meiling Address (Stree		Poute Number City					
and 2 sho saith and n 27 is me er traum	Patrick J. Kelley / so		000 Walnut		and arrangement					
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permit. Pages 1 ar Department of Hea Important: if tem any injury or othe page.	21. Signatura of Funeral Service Licensee	The Ha	22. Name end Addr	ess of Facility Sta sumtown Pik		neral Home	e 21702			
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death certificate be executed e attending physician and bd for use as the burial-transit sician/Medical Examin	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	MULT P		FLUMA			3 4KS			
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Physician: this certific ral director,	axaminer? 1 Yes 2 No Hospitel:	1 Mhpatient 2 □ ER/Ou	tpatient 3 DOA Ot	26. Place of Deeth (6		6 □Other (Specia	4.1			
5 5 5	27. Manner of Death 28e.	Dete of Injury 28b. 1	Time of 28c. Inju		d. Describe how in		97			
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h- 2 h- 0	· GIU		2	27730		1/24/	00			
	30. Name and address of person who completed	cause of deeth (item 23a) ((Type, Print) A CMAR	2773°	BATO	MP 2	1204			
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture	1 6	1						

Kelley, Janet



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 1:35 P.M. **Physician** January 21, 2000 Kaempf Agnes Virginia /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick H Under 24 Hrs. 8. Date of Birth Hours Min. May 100, 19924 If Under 1 Yeer 9. Birthplace (State or Foreign Control Lyland 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys 1□ M 2□ F 75 217-18-7736 Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at Frederick Frederick 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 21702 U.S.A. 7503 Prospect Drive filed within 72 hours after death v Hygiene. Wher than "natural", or items 23. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 ☐ Yes 2 X No If Yes, Give 1 Never Merried 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: Specify: à 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglens Important: if Item 27 Is marked other that any Injury or other traumatic event, that page. Beauty Shop Operator Beautician 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Erma Tobery Ralph J. Little, Sr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Prospect Drive, Frederick, Md. 21702 19e, Informent's Neme/Reletionship (Type, Print) Hubert J. Kaempf/Husband 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Frederick Memorial Park Jan. 25, 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Frederick, Maryland 2000 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen-22. Name end Address of Facility Keeney and Basford Funeral Home M00021 106 East Church Street, Frederick, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical tmmedlete Ceuse (Finel CASIS diseese or condition resulting in death) Examiner Examiner physicien end the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): attending for use as Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed peed page 2 2 2 No 1 Yes 2 No certificate or Attending Physician: director. Be 25. Was case referred to medical exeminer?
1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1, Expatient 2 ER/Outpatient 3 DOA edical Certification: To this 28e. Dete of Injury (Month, Dey Year) After thi funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Naturel 5 Pending death. 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined n 24 hours after de: Ne Funeral Directo pletely filled in by th 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steled. (Check only one) To the Within 2 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp ited cause of death (florn 23a) (Type, Print) + MD Street 300 W Frederick 31. Date filed (Month, Day, Year) Registrar's Signature State

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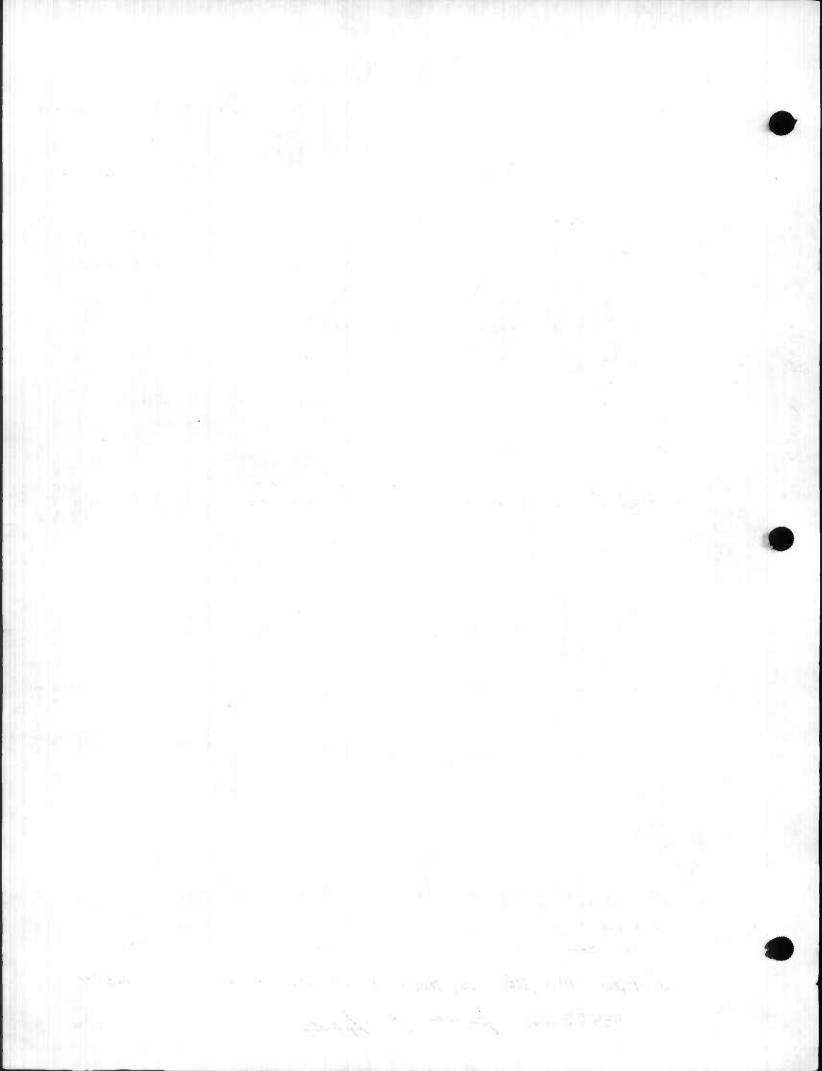
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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Lee Wheatley Inn 1250m 2000 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospita General Dorchester ambridge Dorchester Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Deys 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 10 M 2 F Deys 217-07-7550 March 03, 1910 Mary land Usual Residence of Decedent 10a: State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Dorchester IORS Island 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21669 USA 14. Reca - American Indian, P. O. BOX 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Oyster Shucker Seafood Industr 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Moses elia Lula 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21669 20b. Plece of Disposition (Neme of cometer), cremetory or other place) 20b. Plece of Disposition (Neme of cometery, cremetory or other place) 20c. Location - City or Town, State DORIS ornish 20a. Method of Disposition 1 D Buriei 2 □ Cremetion 3 □ Removel from State 1/29/2000 Taylors Island, MD. Smithville Cemetery 4 Donetion 5 Other (Specify) 21. Signeture of Funerei Service Licensee 22. Name and Address of Facility HOME P.A. HENRY FUNERal 21613 anelle C. 510Washington St. Cambraidge Maryland Approximate 23a. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in deeth) ENS/ON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 28 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ Mo 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes _2500 1. Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No

ed by the attending physician and detached for use as the burial-transit

peen

Mospital or Attending Physicien:
 24 hours after death.
 Funeral Director: After this certific

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

Box 68760,

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Director

À

Completed

Be

2

Funeral

Director

r then "natural", or items 23a or 28a-f short the Medical Examiner must be notified at

al Hygiene.

permit. Pages 1 and 2. Department of Health at Important: if hem 27 is any injury or other trace once.

Physician

/Medical Examiner

should be and Mental is marked

Pages .

Baltimore, Maryland 21215-0020

Examiner

þ

Physician/Medical Completed funeral director, Certification:

27. Menner of Deeth Nature 2 Accident

3 Sulcide 4 Homicide

29e. Certifier

investigetion 6 Could not be

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture and title of certifier

29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Freld 30200/TWS ew

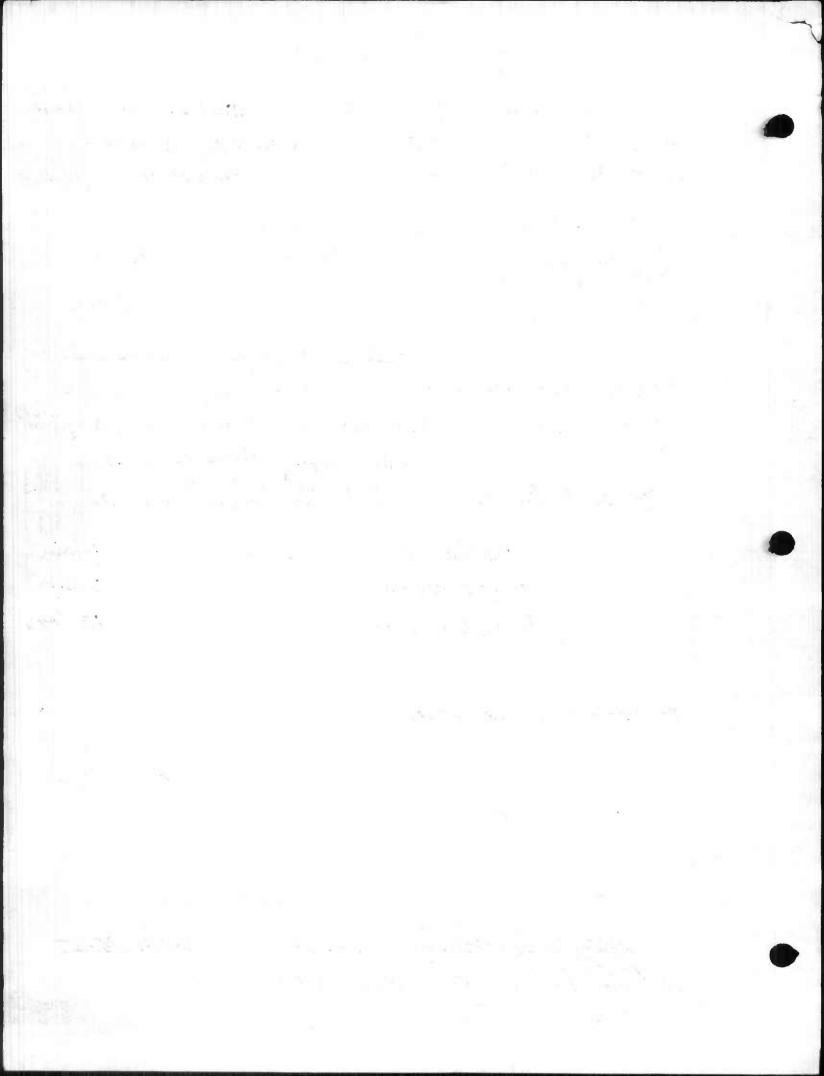
31. Dete filed (Month, Dey, Year)

JAN 28 2000

32. Registrer's Signeture

State Registrar

Medical



Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death **Physician** JAN 630 A.M. 2000 ETHEL MARIE LOWMAN 31 · /Medical 4a Facility Neme (If not Institution, give street and number)
Countryside Protective 4b. City, Town, or Location of Death 4c. County of Death Examiner Care Hampstead
| Hunder 1 Yeer | If Under 24 Hrs. | 8, D Carroll 1811 Albert Rill Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 12 F Yrs. **Director** 212-05-8199 Feb. 12, 1911 Maryland 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Directo Finksburg Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code the M, Lowman United States 21048 2536 Sandymount Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Biack, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Yaer or Datas: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ◯XNo Specify: à 3 ☐ Widowed 4 ☑ Xivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Defense Plant 8 Inspector 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Mary margaret Busick Alfred C. Ports 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Heelth en
Important: if Item 27 Is m
any Injury or other Darlene Hayes/niece 2536 Sandymount Road, Finksburg, MD 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or othar placa) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadow Ridge Memorial Park 2/2 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signature of Funeral Service License 22. Name end Address of Facility Myers Funeral Home 91 Willis Street 21157 Westminster, MD WESTMINS

23a. Part1. Enter the disease, or complications that caused be death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like **Physician** ARGE RIGHT CEREBROUCDOWLAN ACCIDENT Immediata Causa (Final disease or condition resulting in death) 2 weeks /Medical Examiner Dua to (or as a consequance of): Examiner physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): certificate be axecu Box 68760. Physician/Medical Due to (or as a consequenca of): usa as t Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yee 20 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 25. Was casa rafarred to medical examiner? Be 26. Place of Daath (Check only ona) DOMICILIARY Hospital: 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No 1 ☐ Yes CARE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 145 14

Division of Vital Records,

Inneral 24 hours after death. Funeral Director: Al Hospital within 2 1

Registrar

Certification:

31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

27. Manner of Death

1 Naturat

2 Accident

3 Suicide

4 Homicida

(Check only one)

5 Panding

investigation

6 ☐ Could not be

tranco

K. Cellen Ty

28a. Data of Injury (Month, Day Year)

29c. License number D31660

1 Yes 2 No

29d. Date signed (Month, Day, Year) 01/31/2000

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

28d. Describe how injury occurred

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

295 STON ER AVE. WESTMINSTER MO. 21157 HOMSK. GALVINII MS

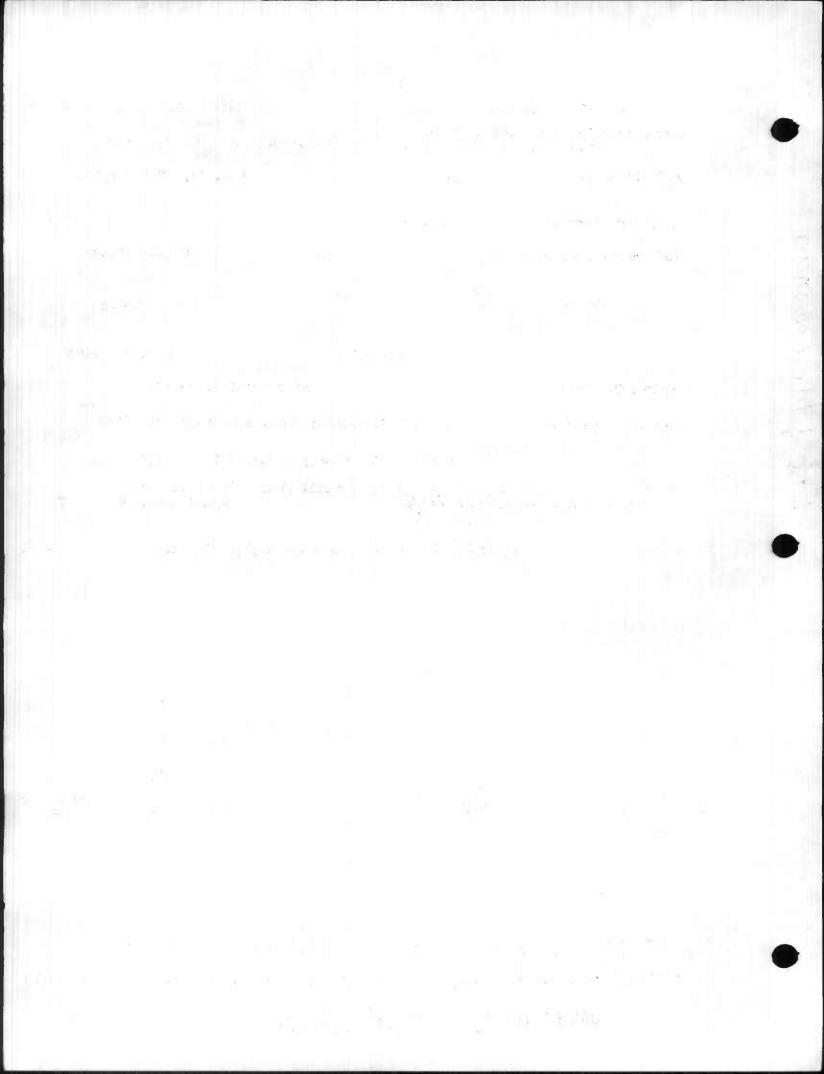
Cortifying Phyeician: To tha best of my knowladga, daath occurred at tha tima, date and place, and dua to tha cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, end due to the cause(s) and mannar stated.

28c. Injury at Work?

32. Registrar's Signature

28b. Tima of

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 1,515 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 FARRELL WRENDLE LYNCH 00 6:30 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 11831 Gumm Point RD Berlin Worcester If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1X M 2□ F Months Days Yrs 197-10-1627 86 3/17/13 MD Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inalde City Limits 1 ☐ Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11831 Gumm Point RD 21811 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married WWII 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Farmer Farming 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Irving W. Lynch Charlotte Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ronald Lynch/ Son 10440 Campground RD Berlin, MD 21811 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Cape Henlopen Crematory 2/1/00 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Burbage Funeral Home 108 William St. Berlin, MD the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) FUFRAL YS Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In deeth) Lest Due to (or as e consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown THANOLISM 24b. Were autopsy findings aveilable prior to 24e. Was en eutopsy completion of ceuse of death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation tniury Natural

Physician /Medical Examiner physician end s the buriel-transit certificate be exec

Physician

/Medical

Director

Funeral

2

Completed

Be

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

8

Department of

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 1s marked other than "natural", or ites

altimore, Maryland 21215-0020

Box 68760

P.O. |

Records,

Division of Vital

with the Marylend

death

Examiner Physician/Medical 98 attending 980 signed by p should be Completed peed hes Be 2 this funeral Certification: il or Attending Pi is efter deeth. Il Director: After t filled in by

2 Accident 3 Sulcide

4 Homicide

(Check only one)

29b. Signature and title of certifier

29e. Certifier

To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1+1

Registrar

Medical

6 Could not be determined

29c. License number

1 Yes

2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of Jerson who completed cause of Seath (Item 23a) (Type, Print)

0, LO KOJIY 46 CZINI ORTH 31. Date filed (Month, Day, Year)

2000

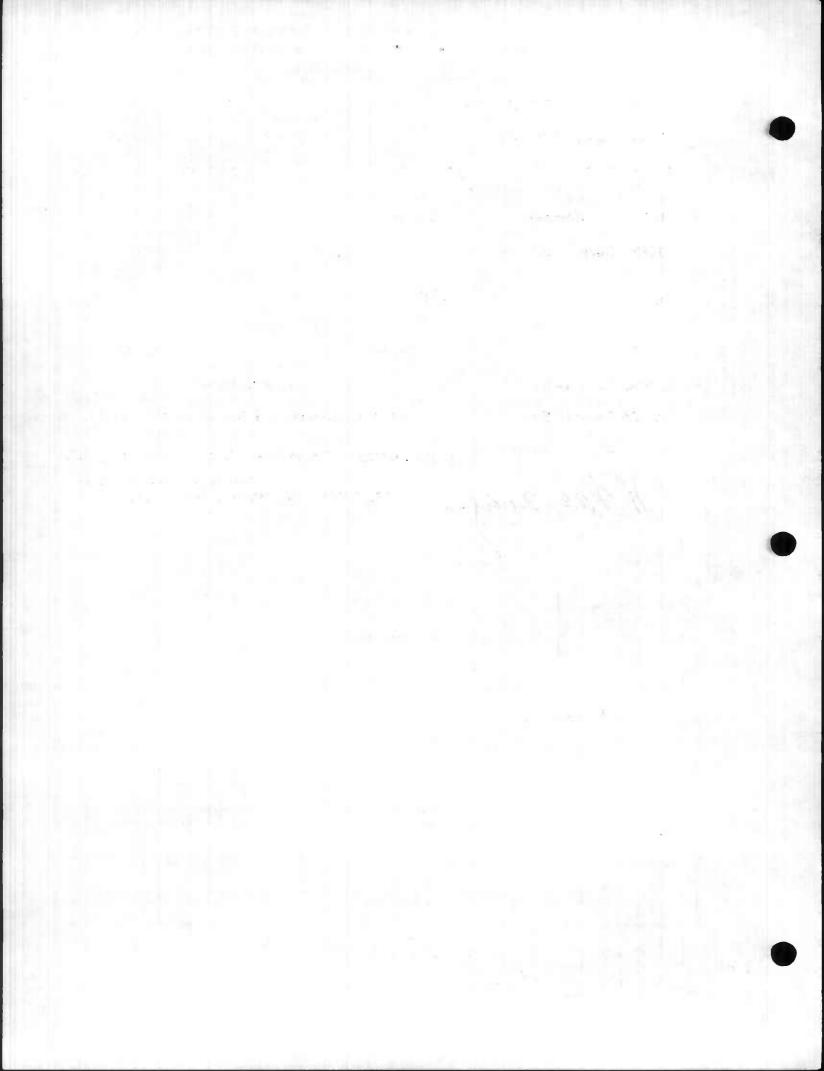
32. Registrer's Signature

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

203 SNOW ST, SNOW HILL, MD. 2863

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.



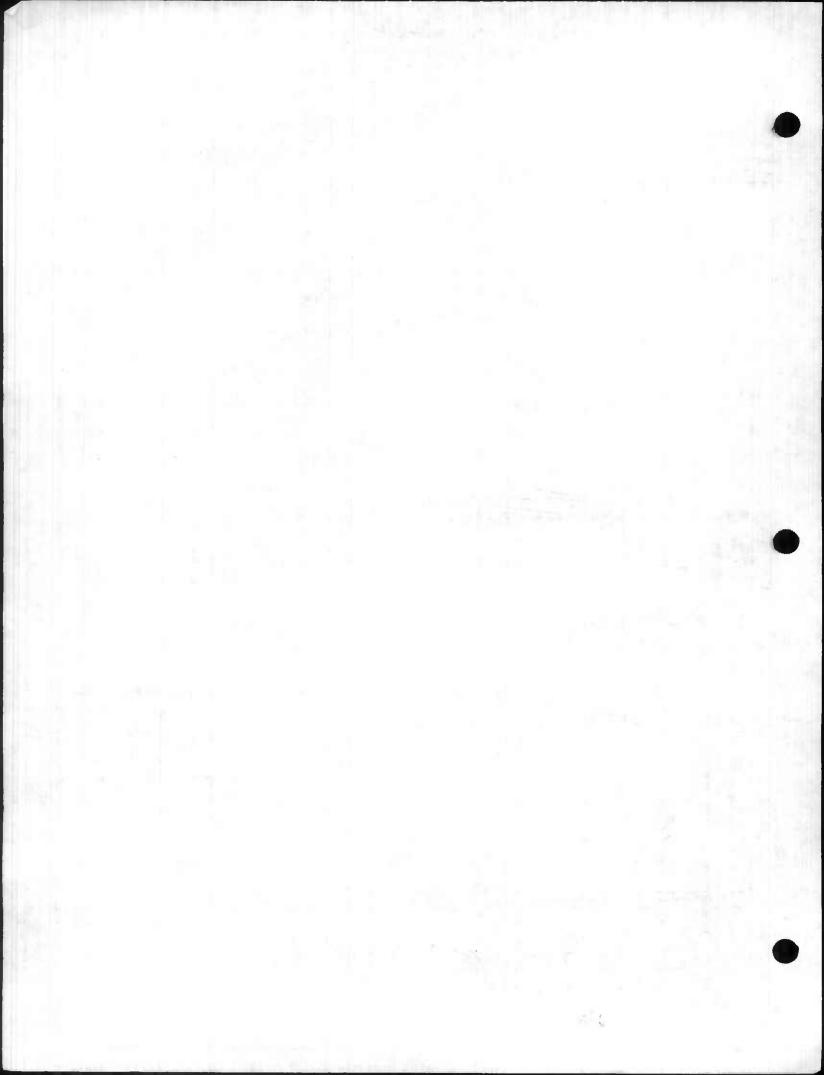
Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 045 6 CECELIA LAKE Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** 22, 2000 6:00 AM Lake Ceceila JAN. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 315 PINE STREET HURLOCK If Under 24 Hrs. DORCHESTER If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 'Funeral Days 10 M 200 F Hours Yrs Nov. 12, 1932 Maryland Director 217-28-3438 67 Usual Residence of Decedent filed within 72 hours after death with the Meryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if then "neturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1₽ Yes 2 No Director Hurlock Dorchester Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21643 USA 315 Pine Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: by Specify: 3-8 Widowed 4 □ Divorced Black. "netural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then. Elementery/Secondary (0-12) College (1-4or 5+) B & G Pickle Co. Processing Line Worker 10 other t 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill thent of Health and Mentel Hism 27 is marked off Mary Selena Ross John Henry 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If Itam 27 is any Injury or other tracence. 911 Bayly Road, Cambridge, Maryland 21613 William L. Lake, Sr., 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burlal 2 Cremation 3 Removal from State 1/29/2000 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland Washington Cemetery 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Signature of Funera Service Licenses P.O.Box 1687, Easton, Maryland 21601 23a. Part1. Enter the in the complication of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) HYDERTENSIVE ATHERSCLEROTIC CARDICULAR DISEASE YERRU Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. been signed by the attending physician should be detached for use as the buria Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yse 2 No 3 Probably 4 Unknown DIABETES MELLITUS of Vital Records. þ 24b. Were autopsy tindings evailable prior to completion of cause of deeth? funeral director, page 2 should Be Completed 24e. Wes an autopsy performed? this certificate hes 1 X Yes 2 No 1 Yes 2□ No lal or Attanding Physician: The safer death.

In Director: After this certificated in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home *** Nesidence 6 Other (Specify) 1√Xes 2□ No 10 27. Menner of Death 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atla within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

**Addical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. Medical 29e. Certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie 22, 2000 O.C.M.E JAN. 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) M.D. JACK M. 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Dey, Year) 32. Registrar's Signature JAN 27 2000



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Dev Month Year **Physician** NAOMI LEWIS 24 JANUARY 2000 2010 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner KENT & QUEEN ANNES HOSPITAL CHESTERTOWN

If Under 24 Hrs. 8. I KENT If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Hours Months Days 1□M 2@F 220-28-683 79 Yrs. Director Usual Residence of Decedent with the Maryland 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No HESTERTOWN Director KENT 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? NECK 7097 USA 21620 DUAKER Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indien, 11. Marital Status Black, Whita, etc. permit. Peges 1 and 2 should be filed within 72 hours effer or Department of Health and Mental Hygiana. If them 27 Is marked other than "natural", or the 1 Never Married 2 Married 1 Yes 2 PNo Specify: Baltimore, Maryland 21215-0020 Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEANE HOUSEWORK 17. Father's Neme (First, Middle, Last) 18. Mother'e Name (First, Middle, Maiden Surname) MARTHA HODGES LEWIS Hompson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MRS MARY HARMON. DAUGHTER 7413 POPLAR AVE. CHESTERTOWN, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stale 20e. Method of Disposition 20 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from Stete CHESTER TOWN MO 01.29.00 EMMANUEL U.M. CEM. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22./Name and Address of Facility 21620 Mo FUNERAL HOME. CHESTERTOWN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, (shock, or reset feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** at least 120 /Medical hypotension Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es/e consequence of): Vrosepsis vs necrotic ulcer Examiner unknown tha bunial-transit requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last and my redema Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 88 hypothyroidism signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pression by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy non-comphance 2 No 1 ☐ Yes 1 TYes 2 No Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) O_L 1 Yes 2 No NZ Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours e To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examinetion end/or Investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. Liçense number D0054890

State Registrar

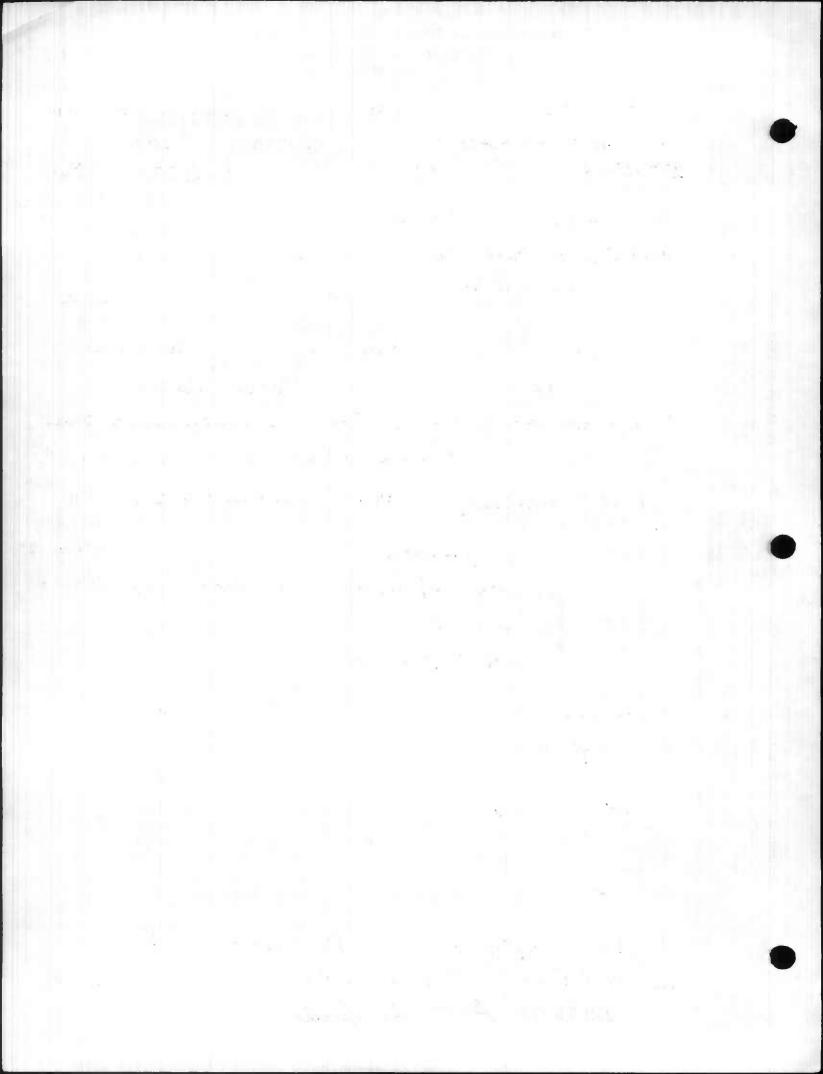
HELEN MORPHY 31. Dete filed (Month, Day, Year)

JAN 28 2000

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

M

6602 CHURCH HILL RD. CHESTER TOWN 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #20ab, c.e. f. 2/8/2000, PMW. Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** ALEXANDER LANGSAM 31, 2000 4:20 P.M. JANUARY /Medical 4a Facility Neme (If not Institution, give street and number) 4h City Town or Location of Deeth 4c. County of Deeth Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. OCHONE Ex. Year) 6. Sex XXM 2□ F 9. Birthplece (State or Foreign 1907 Country) NEW YORK 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 92 Yrs. 097-05-1167 **Director** Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. tnside City Limits Item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at Kensington Montgamery 1 ☐ Yes ※ No CT Directo STAMFORD FAIRFIELD 10e. Street end Number 4907 Strathmore Avenue 10f. Zip Code 10g. Citizen of What Country? 20895 44 STRAWBERRY HILL AVENUE 06902 U. S. A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or frem a 23 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marltal Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 1 ☐ Yes 💹 No WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retirad) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 4 YEARS INDUSTRIALIST MANUFACTURING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) AARON LANGSAM SARAH 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) ANDREW LANGSAM - SON 405 REGENCY COURT, HOCKESSIN. DELAWARE 19707 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from Stete any injury or o MOUNT HEBRON CEMETERY 2/4/2000 FLUSHING, NEW YORK 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Cerebral Vascular /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner ician and burial-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician Physician/Medical the Due to (or es e consequence of) 150 Pert II. Other algriftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed has 1 Yes 2 TNO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Date of Injury (Month, Dey Year) funeral 27. Menner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Hospital or Attending 24 hours after death. 5 Pending investigetion 1 Naturel aftar death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Straet and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide n 24 hours a

To the P within 2 20

with the Maryland

altimore, Maryland 21215-0020

certificeta be executed

Box 68760.

Division of Vital Records, P.O.

State Registrar

Medical

Wilks, mD 31. Dete filed (Month, Dey, Year) FEB 04 2000

29e. Certifier

GARY

(Check only one)

29b. Signeture and title of certifier

He brew Home 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

and

6121 Montose Road Rockville, Maryland 20502

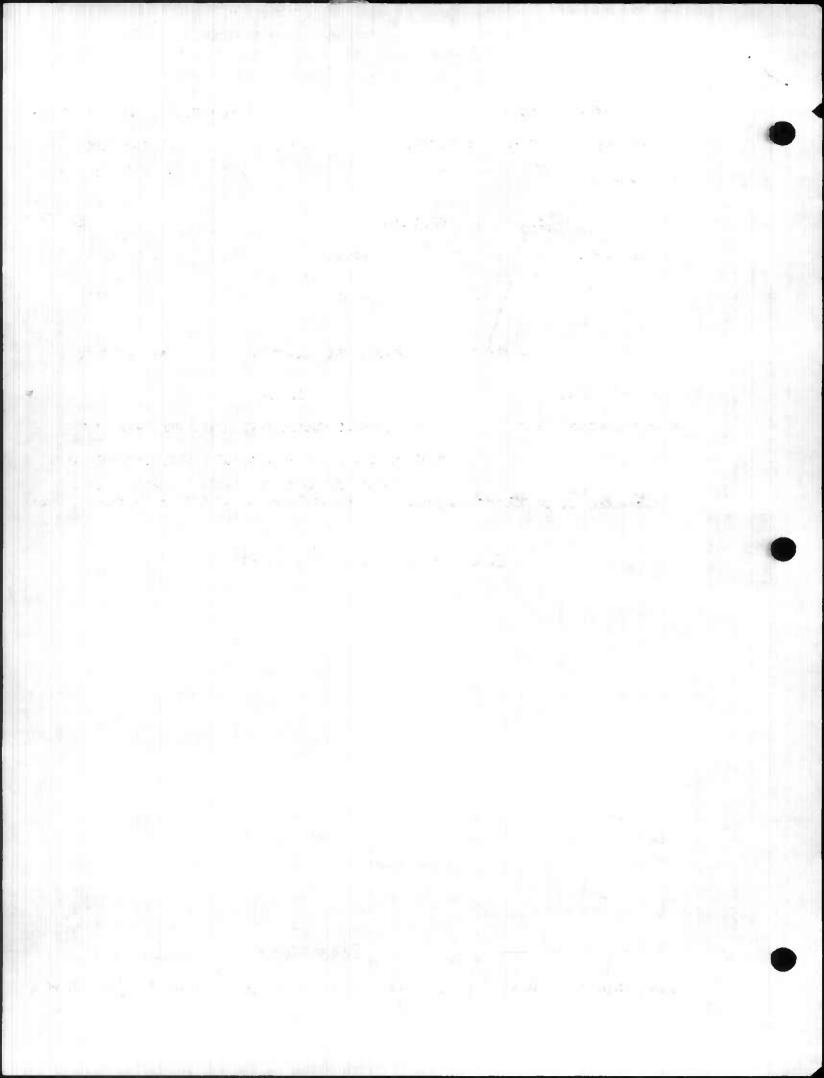
1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner as stated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and menner stated.

29c. License number

D0055258

29d. Dete signed (Month, Dey, Year)

January 31, 2000

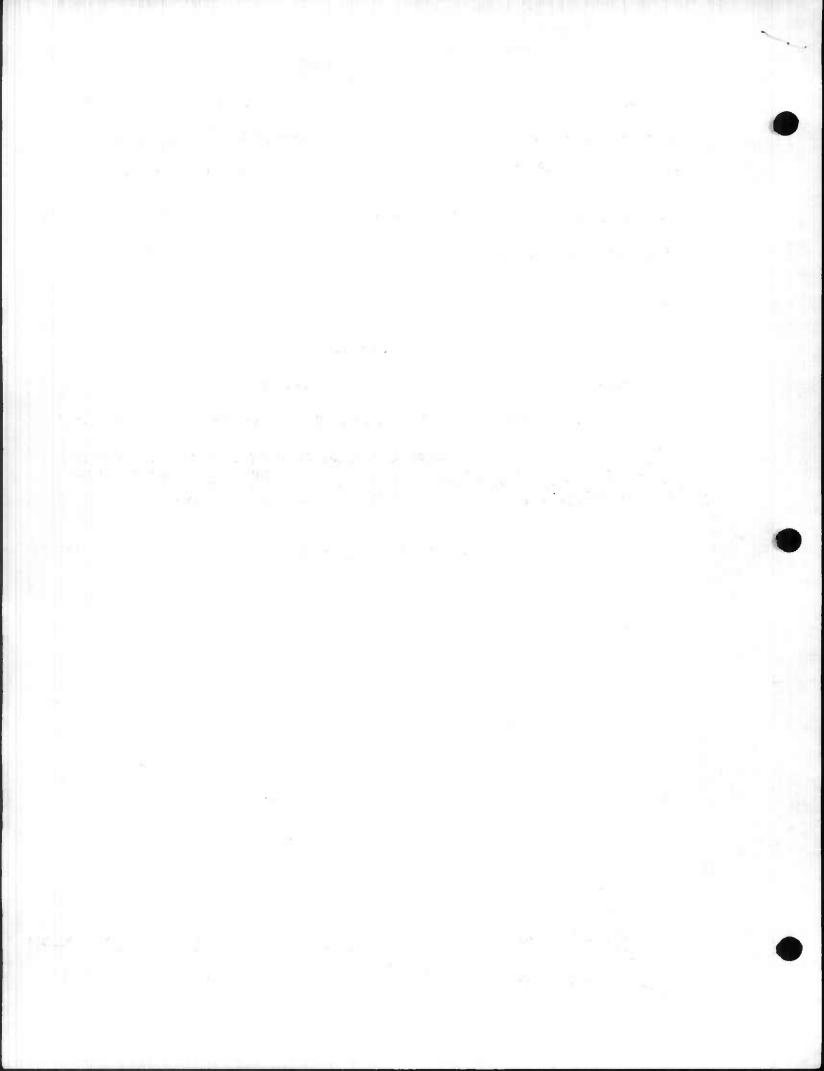


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Amend #29d, 2/1/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 27, 2000 In-Ho Lee 7:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing Home Takoma Park Montgomery If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2\ F Yrs. Director 217-78-0614 90 July 13, 1909 Korea Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notified. 1 ☐ Yas 2 ☑ No Director Maryland Montgomery Silver Spring 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be n 12305 Featherwood Dr., #24 20904 USA Berns 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. then "natural", or lish the Medical Examiner. filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 21215-0020 1 Yes 2 XNo Specify: þ Specify: 3 ◯ Widowed 4 □ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic event 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Eun-Bo Yoon Shi Oh 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Soon Im Chough / Daughter 7805 Wildwood Dr., Takoma Park, Maryland 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/02/00 Adelphi, Maryland George Washington Cem. Bignature of Fungral Service Licer 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate erval Bel Onset and Death Physician Immediate Cause (Final CARCINOMA 46425 disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated marks) Due to (or as e consequence of): Box 68760, Physician/Medical that initiated events resulting in death) Last 2 Due to (or as a consequence of) 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, ģ 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performad? Completed The law **D806 2** 1 Yes ourtificate 2 1No 1 Yas 2 No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 1 27. Manner of Beatl 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attac Attending t Constural 5 Pending investigation 1 Yes 2 No 2 Accident 24 hours after deal Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide ä Hospital 13 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as steled.
20 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated. Medical 29a, Certifier (Check only one) within 2 To the i å 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 2 m

State Registrar 30. Name and astress of person who completed cause of death (Item 23e) (Type Print)

6525

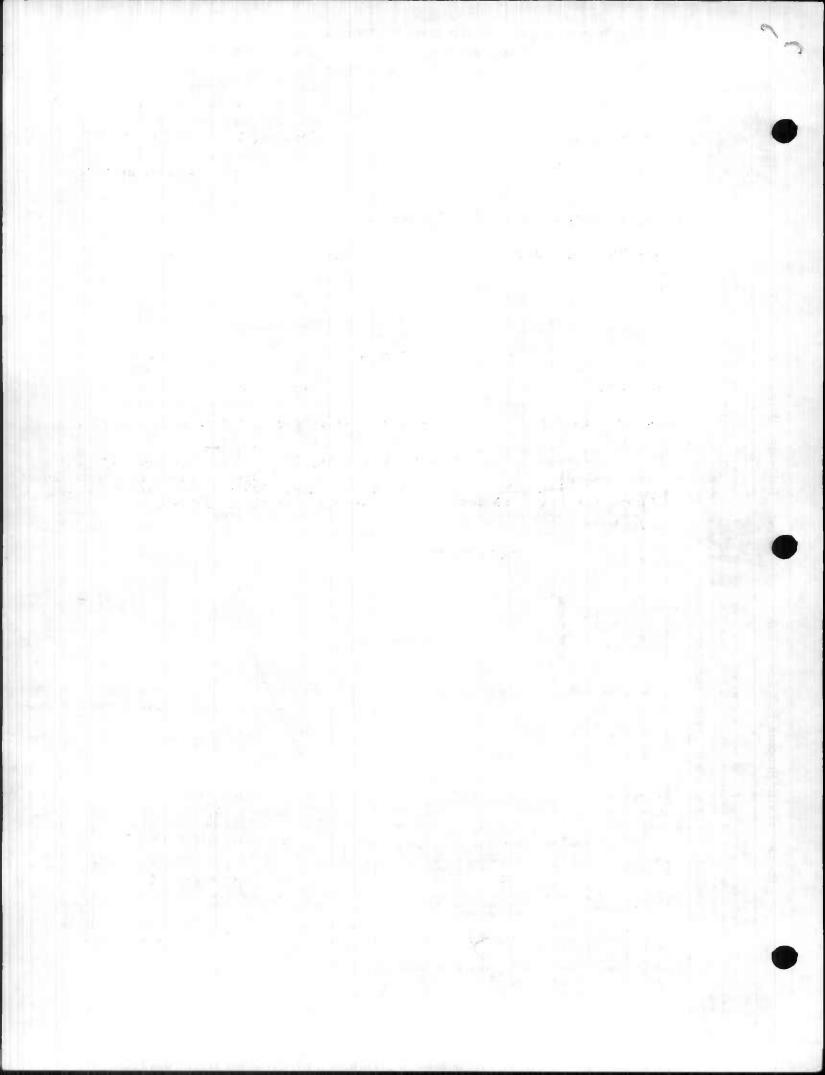
Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04520 Certificate of Death Amend #20b, 2/8/2000, BMW, Montg. Co. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month FEJ JUAY- AIT **Physician** 0635 2000 30 /Medical 4e Eacility Neme (If not institution, give street and number)
5 POUNT GOOTH COUNT 4b. City, Town, or Location of Death 4c. County of Death Examine MONTGOMENY GAITHOUS BURLE 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or rown Country)
Nov. 24, 1979 West Germany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1∭ M 2□ F Days Hours Yrs 20 220-41-9263 Director Usual Residence of Decedent with the Maryland r 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2K No Gaithersburg Maryland Montgomery Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code should be filed within 72 hours after death with Ind Mental Hygiene.
In marked other than "natural", or itema 23a or it marked other than "natural", or unratic avent, the Medical Exercise creative. 5 Rolling Green Court 20878 Taiwan Funeral 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Race - American Indian 11. Marital Stetus Black, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Give Yaar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Asian Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jen-Fu Lee Li-Jue Chen 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) of Health an itam 27 is r Li-Jue Chen Lee/ Mother 5 Rolling Green Court, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete / 20c. Location - City or Town, Stale pemit. Pages 1
Department of Hi
Important: If iten
any Injury or oth
once. Feb. 17, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 Other (Specify) Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 21. Signature of Funeral Service 22. Name and Address of FecilityRobert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, M00689 Rockville, Maryland 20850-2805 disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest failure. List only one cause on each line. Interval Between Onsat and Death **Physician** ASPHYXIATION Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequanca of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as e consequance of): Box 68760. death certificate be Physician/Medical Due to (or as a consequence of): SE USB 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, by 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to Completed completion of cause of daath? page 2 certificate has 2 No 1 Yas 20 No Attending Physician: 25. Was cese referred to medicel examinar? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this funeral 28a. Data of Injury (Month, Day Year) JAUGHY 30 LGO 28d. Describe how Injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work? Certification: 5 Pending investigation Injury 0635 1 Naturai Punnid BAS OUEN HOMO 2 X No death. 1 TYes 2 Accident after deatl Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 5 Recursion Could Office 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2 4 Homicide ò filled in HALE CHITHENSOUR , MD Hospital 24 hours 29a. Cert 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai within 24 hou To the Fune completely fi 25 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and dua to the causa(s) and manner stated. (Check bru) 29d. Date signed (Month, Day, Year) 29b. Signa fure and title of certifier 29c. License number (DME 015736 DOOL OF YARUME 30. Name and address of person who completed cause of death (Item 23a) (Typa, Print)

ORL I. MAGGOUS 1 11125 Rockvil 11125 Rockville Pike, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signatura souls FEB 0 2 2000 Registrar

DHMH 16 Rev 6/95



State

Registrar

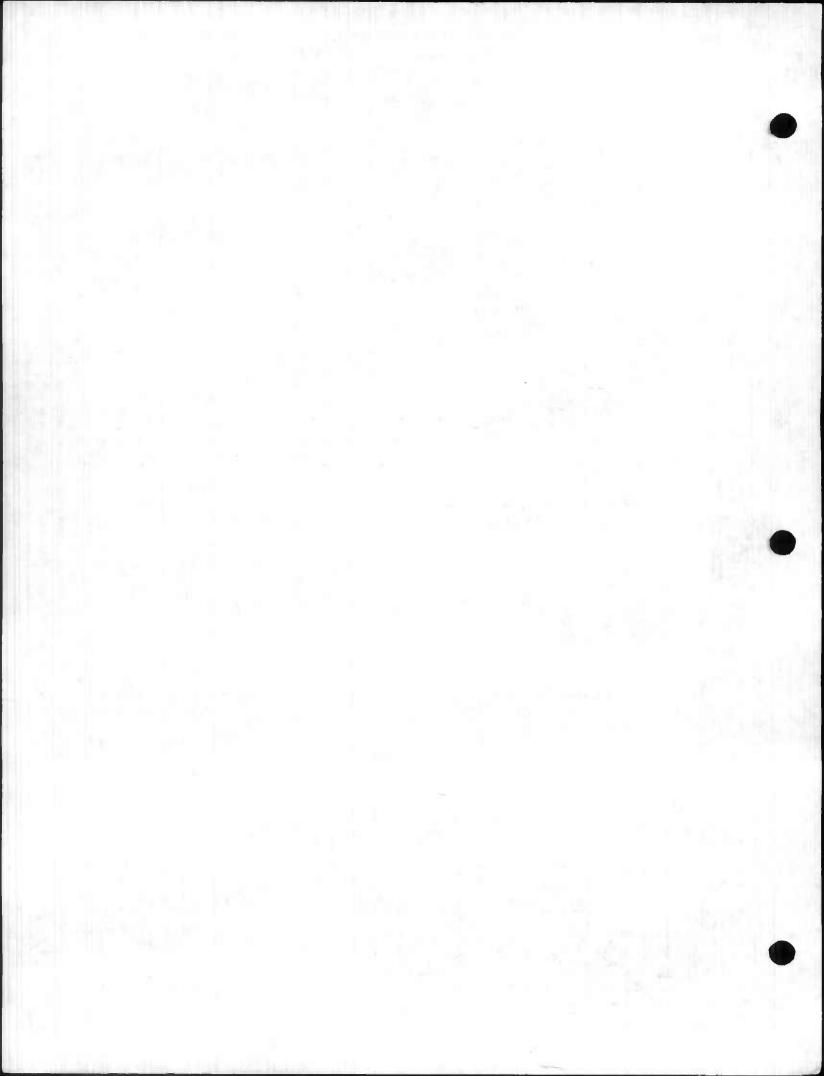
31. Date filed (Md

Day, Year)

2000

JAN 31

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** 26, 2000 4c. County of Death Harry Adrian Leusenkamp, Jr. 1:19 pm /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner Takoma Park Washington Adventist Hospital Montgomery 6. Sax 1(X)M 2□ F If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Hours Yrs. 579-09-9159 82 Director Dec 14, Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow rai", or itema 23a or 28a-f ahov Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours effer death Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23, any Injury or other traumstic event, the Medical Exercises must Funeral 810 Gist Avenue 20910 USA Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 X Widowed 4 □ Divorced WWII Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education fy only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Foreman of Engineering 4 Federal Government 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be P Harry A. Leusenkamp, Sr. Pearl Polly Bell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 810 Gist Ave., Silver Spring, MD 20910

20b. Place of Disposition (Nama of camatary, crematory or other place)

Date

20c. Location - City or Town, Stata Nancy A. Smith / Daughter 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donetion 5 ☐ Othar (Specify) 1/29/00 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Lamal 500 University Blvd. W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** ASPIRATION PREUMONIA Immediata Causa (Final disease or condition rasulting in deeth) /Medical Examiner Examiner CEREBROVASCUL The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Dua to (or as a consequence of): physician s the buriel Box 68760. Physician/Medical Dua to (or as a consequence of) P.O. 1 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? RENAL INSUFFICIENCY. 1 Yes 2 No 3 Probably 4 Unknown BRUNCOSPAGM cate has been signed page 2 should be de Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy FIBRILLATION CONCESTIVE 1 Yes 2 No 1 TYas 2 No ALLURE DEMENTIA. Vital Hospital or Attending Physician: 25. Was casa raferred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To of this 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yas 2 ☐ No 24 hours after deat Punerel Director: 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) in by 4 Homicide pelli 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifiar stely ! (Check only one) within 2 ŝ 29b. Signatura and titla of certifies 29c. License number 29d. Date signed (Month, Day, Year) 0

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Registrar

YUSSUF MD 0. 31. Date filed (Month, Day, Year) State JAN 31 2000

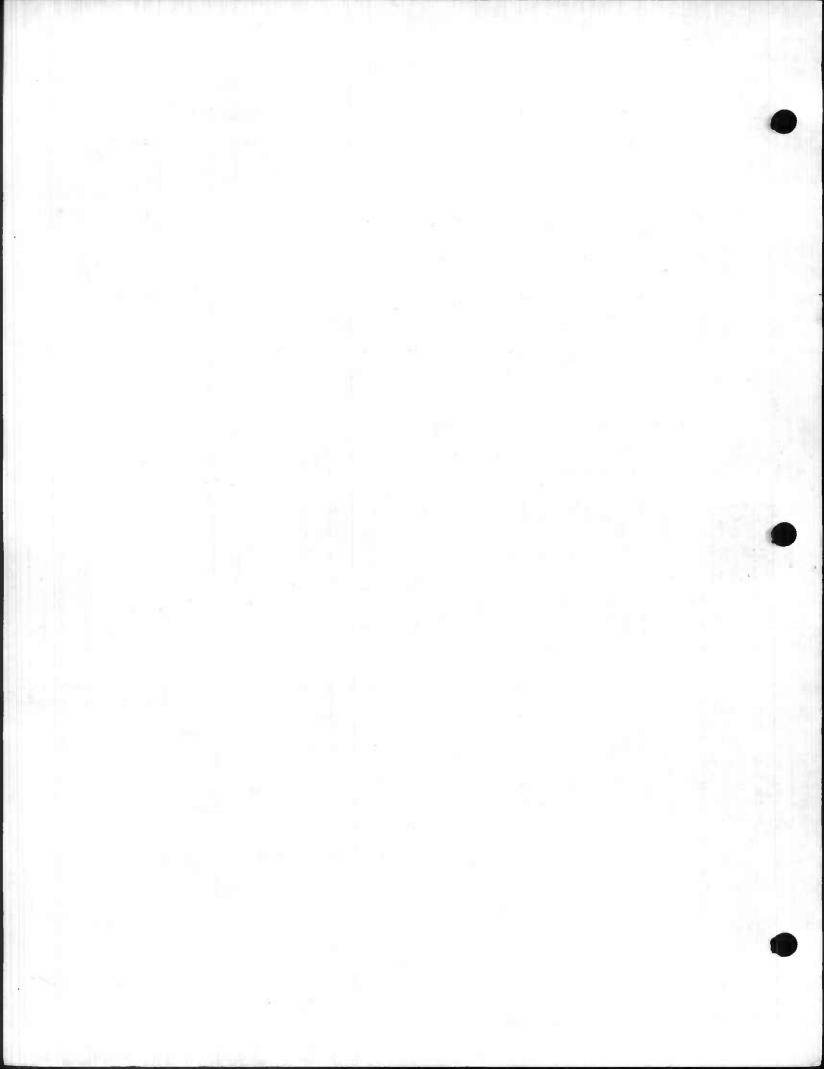
6712 VILLAGE 32. Registrar's Signature Doork

Yuster C

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

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DRIVE



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Neme (First Middle Last) SYLVIA R. LICHTMAN 4b. City, Town, or Location of Deeth 1:12 P.M. 30, 2000 4c. County of Dec 4a Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Deys Hours Min 1□M 2□F Yrs. 075-10-6702 84 NOVEMBER 22, 1915 NEW YORK Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 EAST JEFFERSON STREET 20852 S. A. 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JULIUS ROSEN RAE CHESTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 13201 OLD FORGE ROAD, SILVER SPRING, MARYLAND ELLEN L. ISAACS DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State BETH ISRAEL CEMETERY 2/2/2000 ROANOKE, VIRGINIA

Physician /Medical Examiner

Physician

/Medical

Examiner

10e State

Funeral

Director

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Examiner must be a

'natural', or

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Health.

Department of H Important: If Its any Injury or of

Pages 1 and 2 should be filed within nant of Health and Mental Hygiene.

Baltimore,

P.O. Box 68760

Division of Vital Records.

Directo

Funeral

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Completed

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physician and the burial-transit SE ettending p for use as ed by the detached signed t hes page certificate

The lew requires that the death certificate be executed Physician: this. Hospital or Attending deeth. Director: A in 24 hour. the Funeral Direcwithin 24 ho To the Fune completely fi

Be

2

Certification:

edical

25. Was case referred to medical

31. Date filed (Month, Day, Year)

FEB

5 Pending Investigation

6 Could not be

examiner?

27. Menn of Deeth

Netural

3 ☐ Suicide

29a. Certifier

4 Homicide

State Registrar

20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 21. Signeture of Funeral Service Licensee 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributs to the cause of death? Parkinsons 1 Yee 2 No 3 Probably 4 Unknown Disease þ 24b. Were autopsy findings availeble prior to completion of cause of deeth? Completed 24a. Was an autopsy

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner as stated.

1 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number

28c. Injury at Work?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

1 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28. Place of Death (Check only one)

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Item 23a) (Type, Print)

0 4 2000

Dete of Injury (Month, Day Year)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6121 Montrose Rd Rockville, MI 32. Registrar's Signature

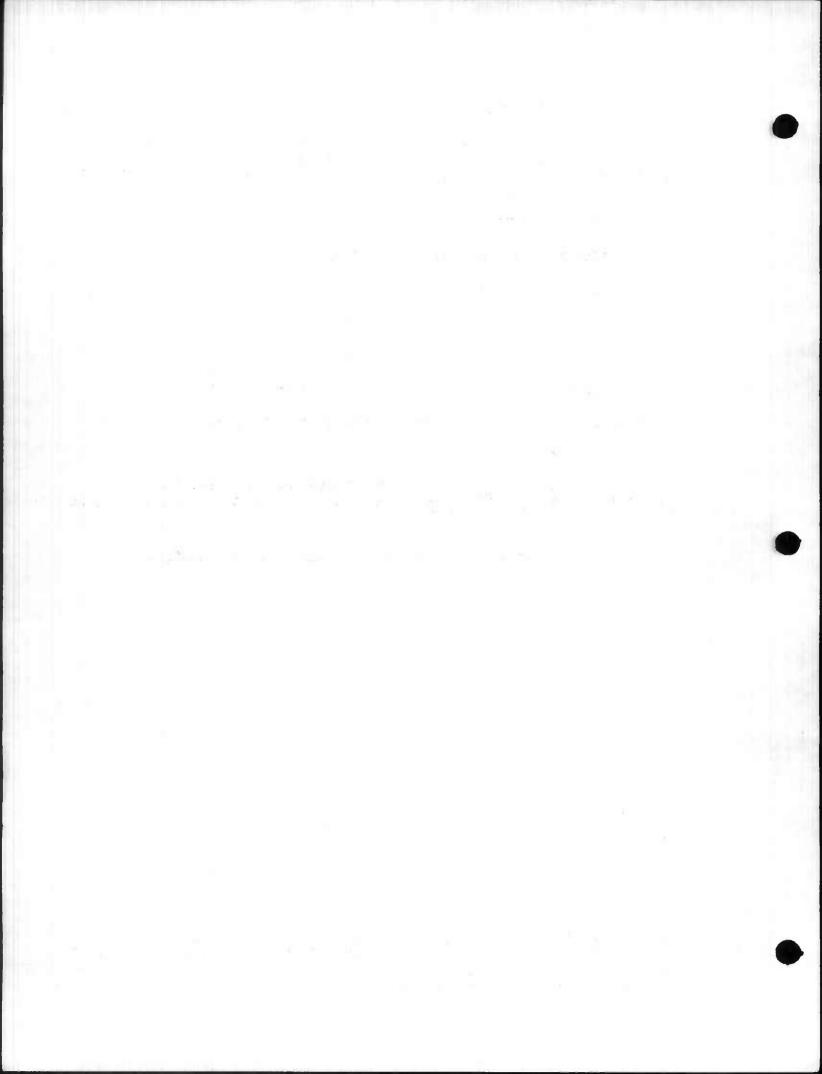
CASTERNA VIET Commercial of the office that we will

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Day KIRSLY S. LINDSAY JANUARY 29, 2000 12:34PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Yeer If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Months 1 X M 2 □ F Director 54 216-92-5886 AUG. 4, 1945 JAMAICA Usuel Residance of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itam 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, tra Medical Examinar must be notified 1 ☐ Yas 2 XNo Director MARYLAND ADELPHI PRINCE GEORGES 10e. Street end Numbar 10g. Citizen of Whet Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours efter death with to Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or items 23a or any injury or other traumatic event. In Medical Control of the 1806 METZEROTT ROAD APARTMENT 401 20783 Funeral JAMAICA 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ▼ No Specify. p Specify: BLACK 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decadant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) CHEF FOOD INDUSTRY 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Surneme) Be J_o HAROLD LINDSAY TINA GARDENER 19a. Informent's Nama/Relationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rurel Route Numbar, City or Town, Stata, Zip Code) 1806 METZEROTT RD APT 401 ADELPHI, MD 20783 BLOSSOM LINDSAY/WIFE 20b. Place of Disposition (Nama of cametery, cremetory or other pleca) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stete 2/8/2000 Spaulding, Manchester, 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from Stata Private family plot 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Sarvica Licensee 22. Name end Address of Fed HINES-RINALDI FÚNERAL HOME, INC. M 23e. Part1. Enter the disease, or complications that causa the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 Approximeta Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in daeth) INFARCTION a Acute Myo Coal AL Examiner Dua to (or as e consequenca of): Physician/Medical Examiner The law requires that the death certificate be executed buniel-tran Sequentielly list conditions, if any, laading to immadiata ceusa. Enter Underlying Ceuse (Diseesa or injury Due to (or es a consequença of) Box 68760, thet Initietad avants resulting in death) Lest Due to (or es e consaguance of) use as P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 5 Unknown Division of Vital Records, by director, page 2 should Completed 24b. Were autopsy findings eveileble prior to 24e. Wes an eutopsy completion of cause of deeth? certificate has 1XYes 2□No or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Reeidanca 8 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yas 2 No Certification: To this. filled in by the funeral 27. Menner of Death 28e. Data of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Netural 2 Accidant 5 Pending invastigation death. 1 ☐ Yas 2 ☐ No To the Hospital or Attand within 24 hours effer deatl To the Funeral Director: 6 Could not be datamined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Spacify) 4 Homicide Certifying Physician: To the best of my knowladga, deeth occurred et the tima, data and plece, end due to the ceuse(s) and mannar es statad.

2 Medical Examiner: On tha basis of exeminetion end/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and due to the ceusa(s) and manner statad. Medical 29a. Cartifian (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Yeer) 30. Nama and addrass of parson who completed cause of death (Item 23e) (Type, Print) Rockville Pike 316, hockville mb Dell 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Death 3. Time of Death Dev Month **Physician** KURT LOEBMANN 01.29.2000 10:45 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva straat and number) 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Deta of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1€M 2□ F Months Hours Yrs Director 492.12.2596 Usual Residence of Decedent JUNE 24, 1913 GERMANY 86 with the Meryland worle 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director GAITHERSBURG MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 1930 WATKINS MILL ROAD USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1 Tes 2 No If Yes, Give Yeer or Detes: 1 ☐ Navar Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) RETAIL/WHOLESALE College (1-4or 5+) Elementery/Secondery (0-12) BEAUTY SUPPLIES SALES PERSON 12 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) FERDINAND LOWBMANN SYDONIE MARX 2 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) permit. Pages 1 end 2 Department of Health a Important: If item 27 is FRAN HERTZ/FRIEND 21113 CHRISMAN HILL CT, BOYDS, MARYLAND 20841 altimore, 20b. Plece of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State any Injury or c 1 ☐ Buriel 2 ☐ Cremetion 3 X Removel from State 4 Donetion 5 Other (Spacify) 2.2.2000 WASHINGTON TOWNSHIP, NJ CEDAR PARK CEMETERY 21. Signeture of Funerei Sergin Licensee 22. Neme end Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 20852 Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Final ACUTE ARRHYTHMIA UNKNOWN disaasa or conditio resulting in deeth) Examiner Due to (or es a consequence of) Examiner physician and s the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of): resulting in daeth) Last USB as ettending P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown SUBDURAL HEMATOMA Division of Vital Records, ð 24b. Were autopsy tindings available prior to 24e. Wes an eutopsy performed? Completed completion of causa of death? page 2 hes 1 ☐ Yes 2 ☐ No 2 No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only ona) Hospitel Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 After this funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of injury 28d. Dascribe how injury occurred 24 hours effer death.
Funeral Director: After the Certification: 28c. Injury et Work? 1 X Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the ceuse(s) end menner stated. Medicai (Check only one) To the P within 2

10

Registrar

31. Dete filed (Month, Day, Year) 2000 03 FEB

29b. Signature and title of certifie

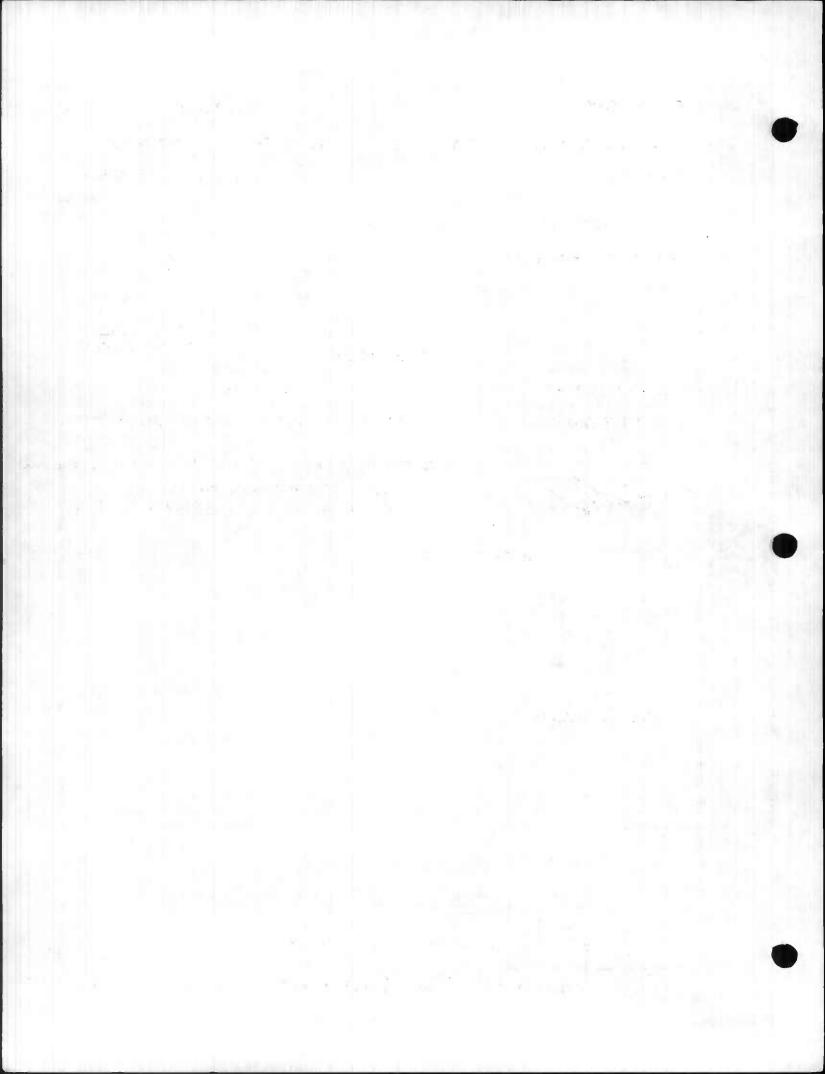
32. Registrer's Signeture

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Center Drive Roc

29c. License number

29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death Dev Month Yes **Physician** James Robert Logan February 1, 2000 11:50 am /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 6. Sex X☐ M 2☐ F If Under 24 Hrs If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Yrs 219-46-6497 53 Director Dec 5, Usual Residence of Decedent the Maryland 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at 1 Yes 2 No Director Maryland Montgomery Wheaton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23a Funeral 12113 Goodhill Road 20902 USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 X Yes 2 No 1967— Wes Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status than "natural", or had the Medical Examiner Bleck, White, etc. filed within 72 hours after 1 Nevar Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: White à 3 ☐ Widowed 4 🖾 Divorced 1969 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) 12 Printer permit. Pages 1 and 2 should be filed to Department of Health and Mental Hogie Important. If Item 27 is marked other I any Injury or other traumatic event, III Graphic Arts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 88 2 Thomas Manley Logan, Sr Mary Margaret Coates 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Logan/ Brother 11403 Idlewood Road, Wheaton, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 X Cremation 3 ☐ Removet from State 4 □ Donetion 5 □ Other (Specify) Metropolitan Crematory 2/2/00 Alexandria, VA 21. Signeture of Funerel Sarvice Licensee 22. Neme end Address of Fecility Francis J. Collins Funeral Home, Inc. 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

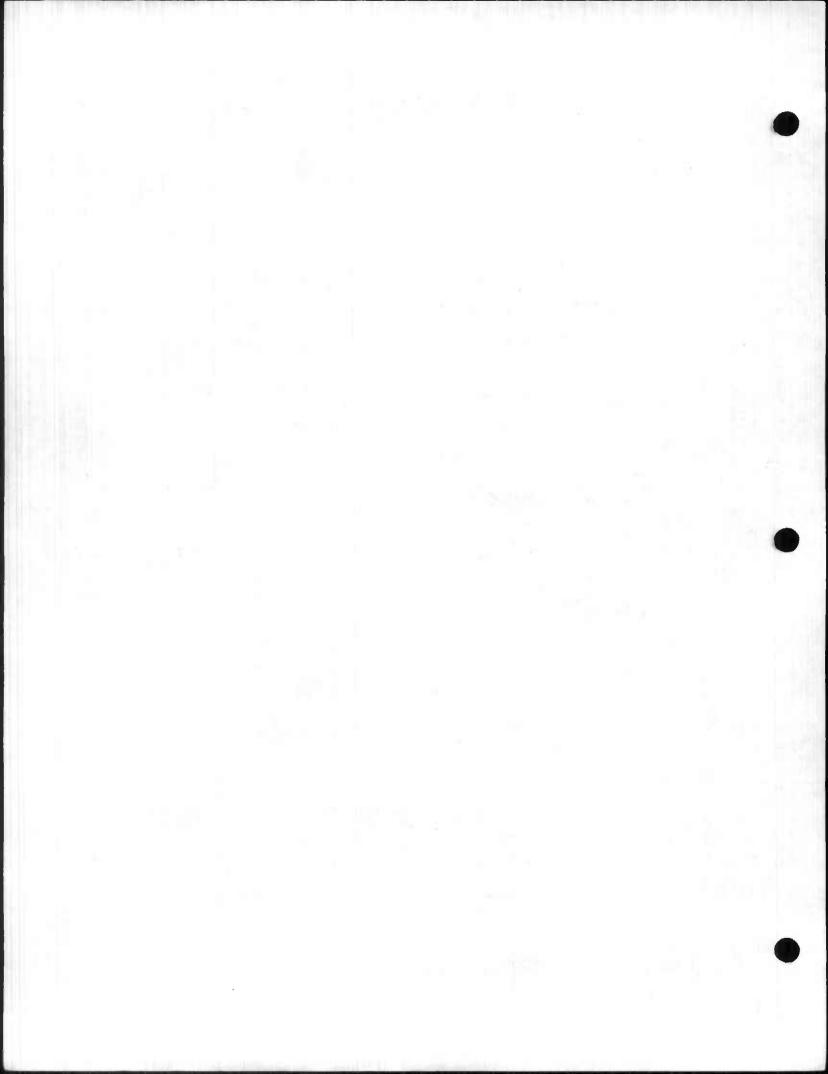
Approximate

Approximate Approximete Intervel Between Onset and Death **Physician** /Medical tmmediete Cause (Finet disease or condition resulting in death) Pneumonia weeks Examiner Due to (or as a consequence of) Respiratory Failure weeks physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseea or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Multiple sclerosis years Physician/Medical Due to (or es a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2XXNo 1 ☐ Yes 2 No certificata Attending Physician: Be 25. Wes cese referred to medicet examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No death. investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) 29b. Signatura and titla of certifiar 29d. Data signed (Month, Day, Year) 050678 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3835 Farragut Ave., Rajeev Batra, N 31. Date tiled (Month, Dey, Year) MD Kensington, MD 20895

State Registrar

FEB 03 2000

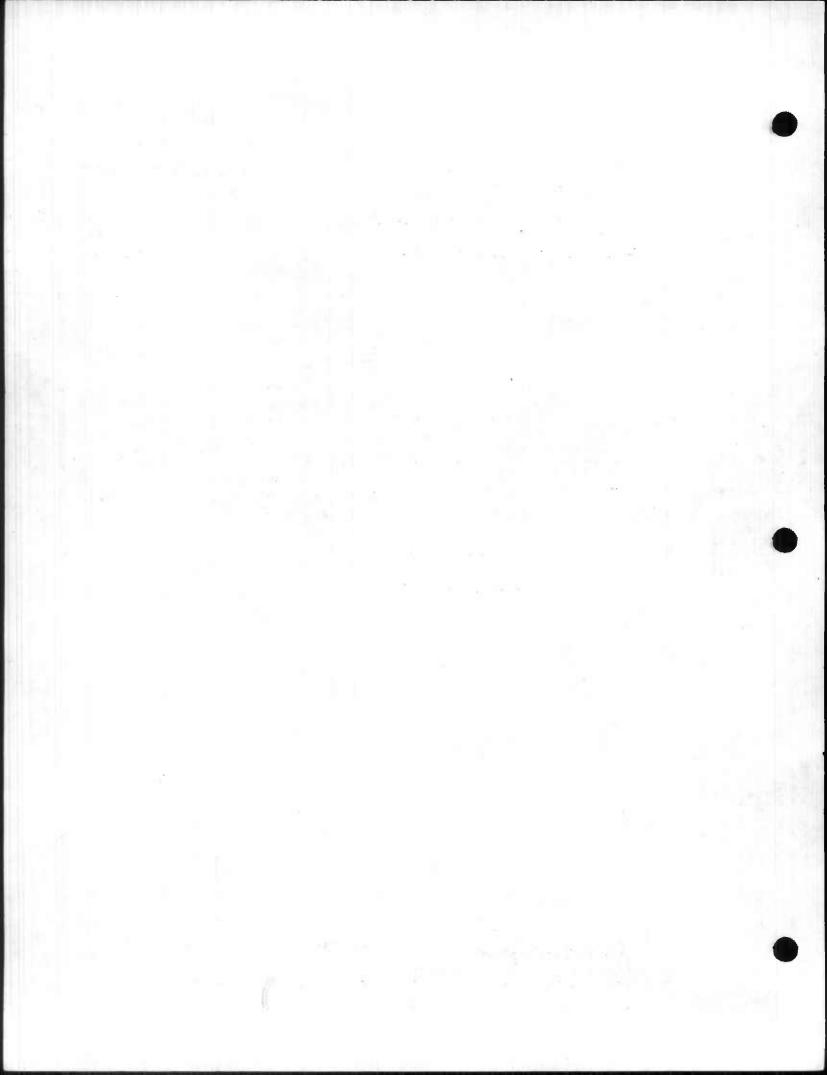
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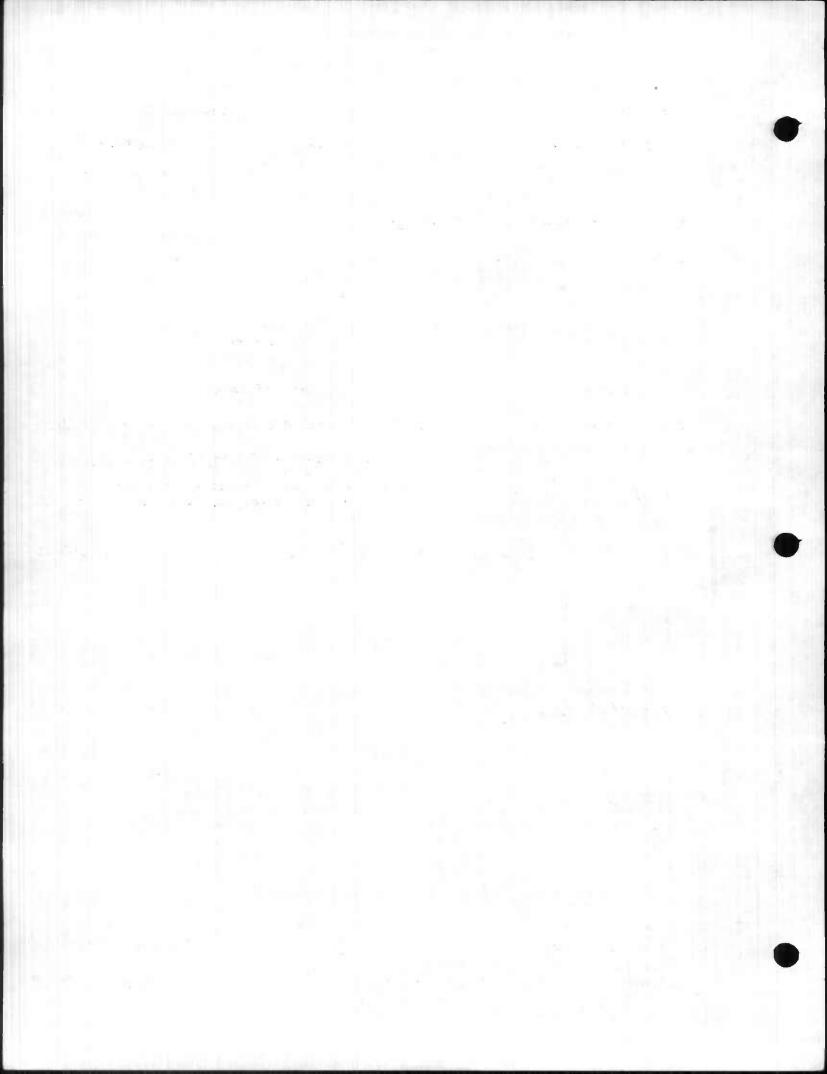
State of Maryland / Department of Health and Mental Hygiene 0 0 4527

				Cei	rtificate of	Death			Reg. No.		
		1. Decedent's Name (First, Middle, I	ast)					2. Date of De		Vers	3. Time of Death
	Physician	Margarer I. Lon	g					Month Januar	y 30, 2	Year 000	7:58pm
1	/Medical Examiner	An Challing his and danking the same	ive street and number)			4b. City, Tox	wn, or Loc	cation of Death			
		Woodside Center				Silver	r Spi	ing	Mont	gomer	CV
	Funeral	5. Social Security Number 6.		yrs. last birthday)	If Under 1 Yea	r If Under a	-	8. Date of Bir (Month, De		0	place (State or Foreign
п	Director	168-14-5066	1□M 2)(F	81 Yrs.	Months Days	Hours	Min.	Feb. 15	1918	Penn	sylvania
	TO .	Usual Residence of Decedent		c. City, Town or Lo							
	the star	10a. State 10b. County	1	Od. Inside City Limits							
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		11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of	Hispanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		e - Americ	
020	hours after hursf, or its at Examine of by Fu		1 Yes 2 No If Yes, Give Year or Dates:		1□Yes 20XN					y: Wh:	
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Baltimore,	Pages nert of mt: if its iry or o	1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, cres	matory or other pi			an. 31,	Alexan		
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	/Medical	Immediate Cause (Final disease or condition	Metastati	c Carcin	oma					1	Months
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	the at hed for	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying ceuse g	iven in Part I.		23b. Dld	tobacco uss co	otributs to	o the cause of death?
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of V	Q 60 7		Hospital: 1 Inpatient	2 ER/Outpatier	nt 3□ DOA	ther: 4 🖾 Nu	rsing Hon	na 5 Resi	dence 6 Oth	ner (Specil	(y)
	ding Ph. After th funeral	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of	28c. Inj	ury at ork?	2	8d. Describe	how injury occur	теб	
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Division	ball or Attanding P is after death. al Director: After the did in by the funera Certification:	3 Suicide 6 Could not detarmine		At homa, farm, str	eet, factory, office	•	2	8f. Location (: City or To		ber or Rura	al Route Number,
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	To the Hospital or within 24 hours after To the Funeral Director completely filled in Medical Cert	29a. Certifier 1 Certifying F (Check only ane) 2 Medical Ext	thysician: To the best of my aminer: On the basis of axa	knowledga, death mination and/or inv	occurred at the vestigation, in my	time, date and opinion, deat	d place, a th occurre	nd dua to tha	cause(s) and m date and place,	annar as s	stated. tha cause(s)
	ithin on the omple	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number	-		29d. Date signe	d (Month	Day, Year)
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	6	mymmac	pro		D-32	JJ2			January	21,	2000
		30. Name and address of person who				# 0 0	00 01	1		M.J. O	0002
		Dr. Suresh K. (-	9801 Geo	rgia Ave	e. #Z-2	20 51	iver S	pring, I	1d. Z	0902
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State of Maryland / Department of Health and Mental Hygiene

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Joseph A. Lynch February 1, 2000 12:02 mm February 1, 2000 12:02 mm	Dhusisian	1. Decedent's Name (First, Middle, La		. Time of Death										
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Source S	within 7 wit		College (1-4or 5-	Bur	eau of	use retired) Land	Manage	Gover	nment					
O Joseph Lynch Source Lynch Wife 15300 Pine Orchard Drive, Silver Spring, MD 20906	D HAND	17. Father's Name (First, Middle, Las				1	8. Mother's Nan	ne (First, Middle, M	leiden Sumem	Θ)				
Privation Continue	id be entalled to every contalled to every contalle	Joseph Lynch					Mary Mc(Cormick						
Physician / Medical Cause (Final disease or complications in Sold and the death in Communication of Control (Specify) Physician / Medical Examiner Physici	Shou nd M M mark		City or Town,	State, Zip Cod	de)									
Physician Physic	M dd 2 dd	Alma C Ivnch / I	Jifo	153	OO Dir	000	hard Dr	ivo Cilv	or Car	ina M	20006			
Physician / Medical Examiner Physic	Te, Te, Other other	20a. Method of Disposition		20b. Place of D	isposition (Na	ame of		Date 2	Oc. Location -	City or Town,	State			
Physician Phys								2/4/00 5	ilver	Spring	. MD			
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Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Data of Death 3. Time of Death Day Year 4:45pm nomas Janyan 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Frederick Memorial Hospital Frederick Frederick If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 10XM 20 F Months Days Yrs. 66 Jan. 1933 Maryland 214-32-2624 Usual Rasidence of Decedant 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7833 Gambrill Park Road 21702 U.S.A. 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 24☐ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian. Black, Whita, atc. 1 □ Navar Marriad 2 □ Married 1 Yas 2 No Specify. Specify: 3 □XWidowed 4 □ Divorced White 15. Decedant's Education (Specify only highast grada completed) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 18b. Kind of Business/Industry Frederick County Board Elementery/Secondary (0-12) Coliega (1-4or 5+) Custodian of Education 18. Mother's Neme (First, Middle, Malden Sumama) 17. Fathar's Nema (First, Middla, Last) Quincey T. Lowery Lena Dean 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Typa, Print) Marie Fisher (Sister) 4930 Old National Pike, Frederick, MD 21702 20b. Piaca of Disposition (Nema of cematary, cramatory or other place) Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Resthaven Mem. Gardens 1/19/00 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Lice 22 Name and Address of Eacility & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Entar the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximsta Interval Batwaan Onsat and Daath by ot antar the mode of dying, such as cerdiac or respiratory arrest, Immediata Causa (Final disaasa or condition rasulting in daath) Arterioscleratic Cardiovalcular Disease Due to (or es e consequence of): Due to (or es a consequance of): 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 20 No 26. Placa of Deeth (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2ER/Outpatient 3 DOA 1 Inpatient

Physician /Medical Examiner

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24 hours efter death.
 Funeral Director: A sletaly filled in by the function

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requires that the death certificate be executed

The law has

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Box 68760,

P.O.

Division of Vital Records,

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ed other than "natural", or herre 23s or event, the Medical Examiner must be r

normit. Pages 1 and 2 should be filed within 72 hours after begariment of Hestith and Mental Hyglens. Important: If Item 27 is marked other than "natural", or the

Baltimore, Maryland 21215-0020

Directo

Funeral

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The Maryland

Sequentially list conditions, if any, laeding to immadiata causa. Enter Underlying Cause (Disaese or injury that initieted avents rasuiting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

25. Was cesa rafarred to madical exeminer?

12 Yas 2 No 27. Manner of Death

5 Pending invastigation 1 Neturel
2 ☐ Accident 6 Could not be datarmined 3 Sulcida 4 Homicide

28a. Dete of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work?

1 Yas 2 No 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Describe how injury occurred

(Check only one)

29a. Certifie

Medical Examiner: On the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature

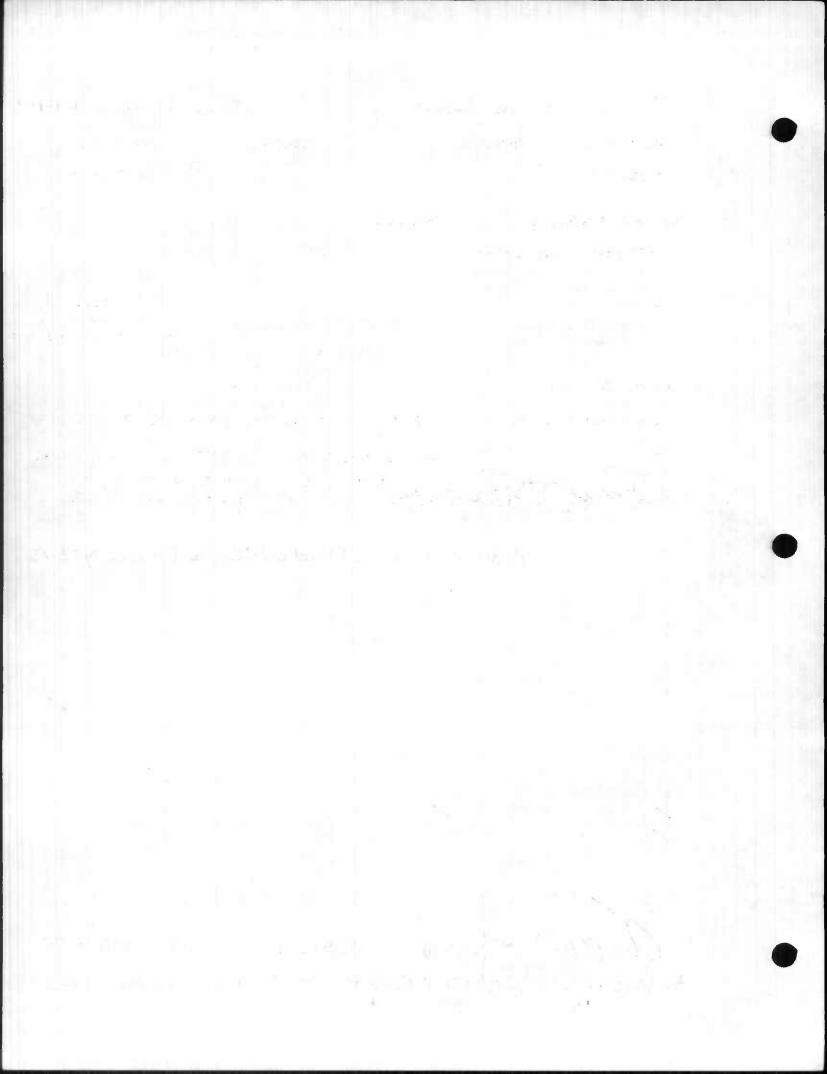
29c. Licanse number D35164

29d. Data signed (Month, Day, Year) JANUARY 18, 2000

30. Nama and addrass of person who completed cause of chain (item 23a) (Type, Print)

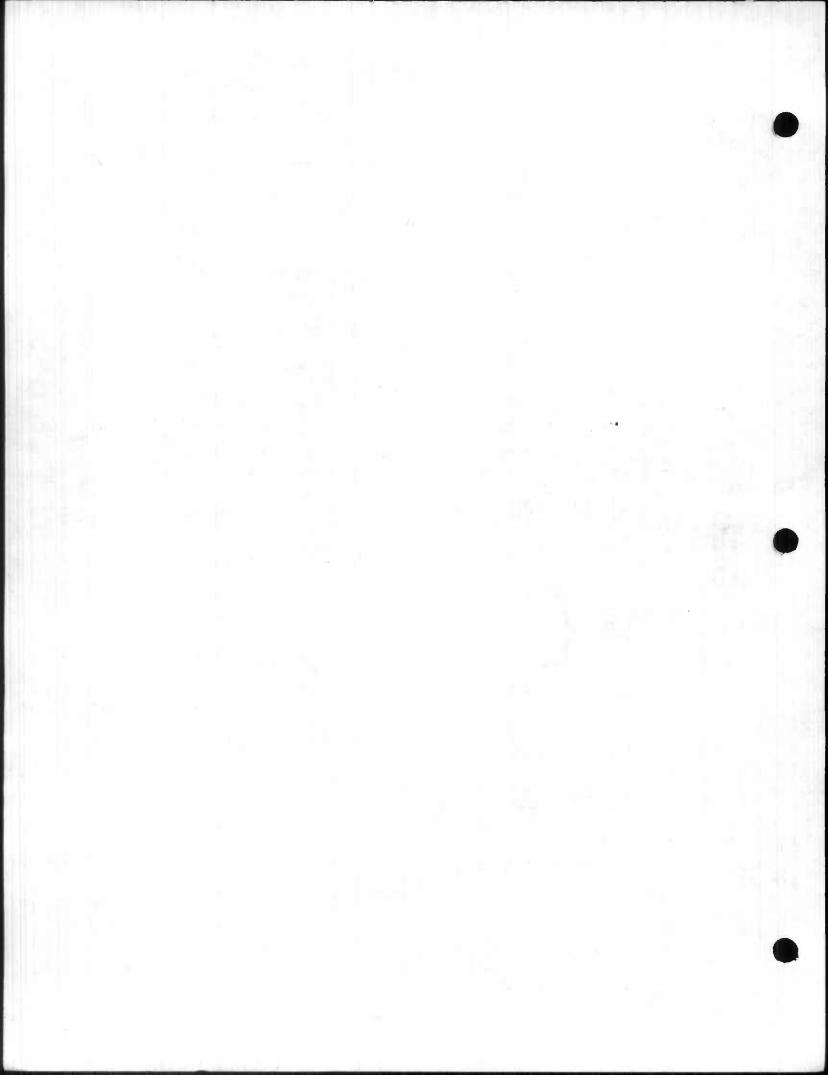
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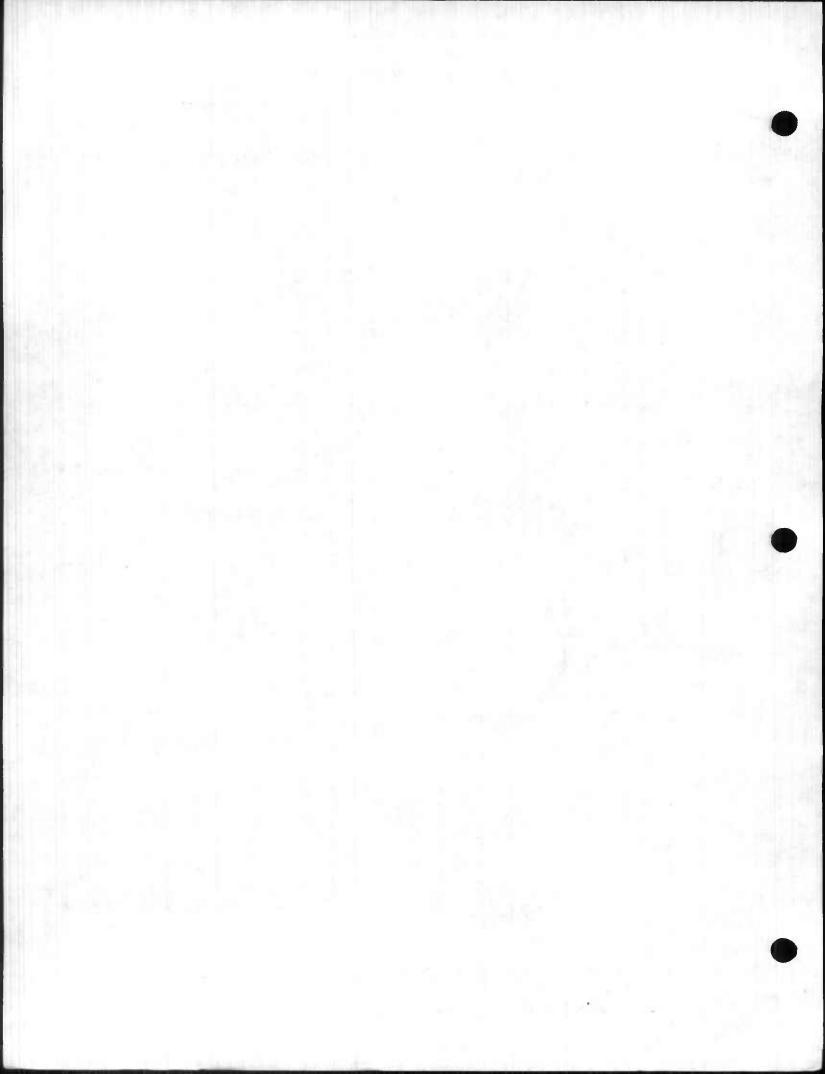
State of Maryland / Department of Health and Mental Hygiene

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	Physicial	_	Lawrence Ernest Lee								Januar	Day ~√7 21	. 2000	
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	P wit	E .	7029 Rock	Creek D	rive			2	1702			USA		
	dead dead	ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U	S.	13. Was De	cedent of I	lispanic Origin? (S an, Mexican, Puer	pecify Yes or N			nerican Indian,
0	or the	2	1 Never Marri	ed 2 Married	I OXYes 2 □ I				s 20(No	Specify:	io nican, etc.)		Bleck, Wi	inte, etc.
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yla			William Jennings Lee 19e. Informant's Nome/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steh											
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			30. Name and addition	ss of person who	completed cause of d	eath (Iten	23a) (T	ype/Print)		. /	1	1/	, 0	21702
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	State Registra	7	U. Date Inject (MORE	JAN'2	7 2000 D	sene	w	1	(/				



State of Maryland / Department of Health and Mental Hygiene 0 0 4531

				Cer	tificate of	Death	Re	g. No.	0	4001					
	Physician	1. Decedent's Name (First, Middle, Last			TF 5%		2. Date of Death		Year	3. Tima of Death					
	/Medical Examiner	Frank Paul Lope 4a Facility Name (If not institution, give Frederick Memor	street and number)			4b. City, Town, or L Frede	Month Januar ocation of Death Prick	y 20, 2	2000 Fred	1:30 PM erick					
	Funeral Director	5. Social Security Number 6. Se 079–18–7486	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yeer Months Days		8. Date of Birth March Der.	Yedr 908	9. Birthple Count	ace (State or Foreign					
	Maryland H show find at tor	Usuel Residence of Decedent 10a. State Maryland Frede	erick 10c. Cm	y, Town or Loc	cation	Frederic	k		10	od. Inside City Limits					
	ar death with the Maryla thems 23e or 28e-1 shot ner must be mutified at uneral Director	10e. Street and Number 9249 Ridgefield	l Circle		10f. Zip Code	21701	10	10g. Citizen of What Country? U.S.A.							
	by F	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: UNKNO		Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Speen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	en Indian, olc. ite						
15-0	ed wmn 72 ho ygiens. wr than "natur rt, the Medical Completed	15. Decedent's Edu (Specify only highest grad		16a. Decede	ent's Usuai Occu kind of work done	pation during most of work d)	sing	6b. Kind of Bu	siness/ind	ustry					
Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 Department of Health and Maryland 12216-0020 the Mo	Elementany Secondary (0-12)	College (1-4or 5+)	Butc		10)	r	etail l	butch	er shop						
	ares o	17. Fether's Neme (First, Middle, Last) Unknown				18. Mother's Nam Jent	e (First, Middle, N	laiden Surname	9)	Unknown					
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imore	Pages 1 I	20a. Method of Disposition 20b. Piece of Disposition (Name of completely) 21, 2000 21, 2000 21, 2000 21, 2000 21, 2000 22. Name and Address of Fecility 23a. Part 25a. Par													
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		resulting in death) Last	Due to (o	r as e consequ											
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Division or Attended the deatl	tal or Attending Programme and Director: After the did in by the funeral Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homlcide determined	28e. Place of Injury - At he building, etc. (Specif				28f. Location (Str City or Town		er or Rure	Route Number,					
	No the Hospital or Attention 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical		sician: To the best of my kno ner: On the basis of examina and manner stated.												
_	Me Me	29b. Signature and title of certifier			29c. Licen	se number	25	d. Date signed	Month, L	Day, Year)					
		> Mul Wara	/ ms		D4=	7611	J	ANUNCY	21, 2	000					
		30. Name and address of person who or NEIL KARAVOIEKAL, 1	mpleted ceuse of death (Item 10 1475 TANE	n 23a) (Type, F	204 F	MORNICIC	MD ZIT	02	ji A						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 4 5 3 2 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **JEFFERSON** JANUARY 29, 2000 LITTLE 11:45 AM 4e Facility Nema (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 5841 DETRICK ROAD MT. AIRY
If Under 24 Hrs.
Hours Min. FREDERICK If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Hours Months Days 1 X M 2 ☐ F 64 419-44-9682 MARCH 27, 1935 **ALABAMA** Usual Residence of Decedant 10b. Counts 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yas 2 No Maryland Frederick Mt. Airy 10e. Street and Number 10f Zip Code 10a. Citizen of What Country? 5841 Detrick Road 21771 United States 12. Was Decedant Evar in U,S. Armed Forcas? 1 ⊠ Yes 2 □ No If Yas, Giva 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Nevar Married 2 ☑ Married 1 Yas 2 No Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Welder 11 Construction 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Little Cynthia Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Little / wife 5841 Detrick Road, Mt. Airy, MD 21771 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Clover/Hill Cemetery 2/01/00 Dayton, Virginia 22. Nama and Address of Facility
Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death product in the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Metastat2 Squamera Immediata Ceusa (Final Gmo diseesa or condition rasulting in death) Sequentially list conditions, if any, leading to immediata causa. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

physicien s

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Box 68760,

P.O.

Records,

Division of Vital

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific

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r than "natural", or itse the Medical Examiner filed within 72 hours after

Hygiene.

Pages 1 and 2 should be nort of Health and Mental Department of Health and Mental important: if Item 27 is marked o any Injury or other traumatic av-

altimore, Maryland 21215-0020

Examiner Physician/Medical P Completed Be

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Tes 2 No 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28e. Data of Injury (Month, Day Year) 27. Manger of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 Yas 2 No invastigation 2 Accidant 3 Suicide 6 Could not be 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier

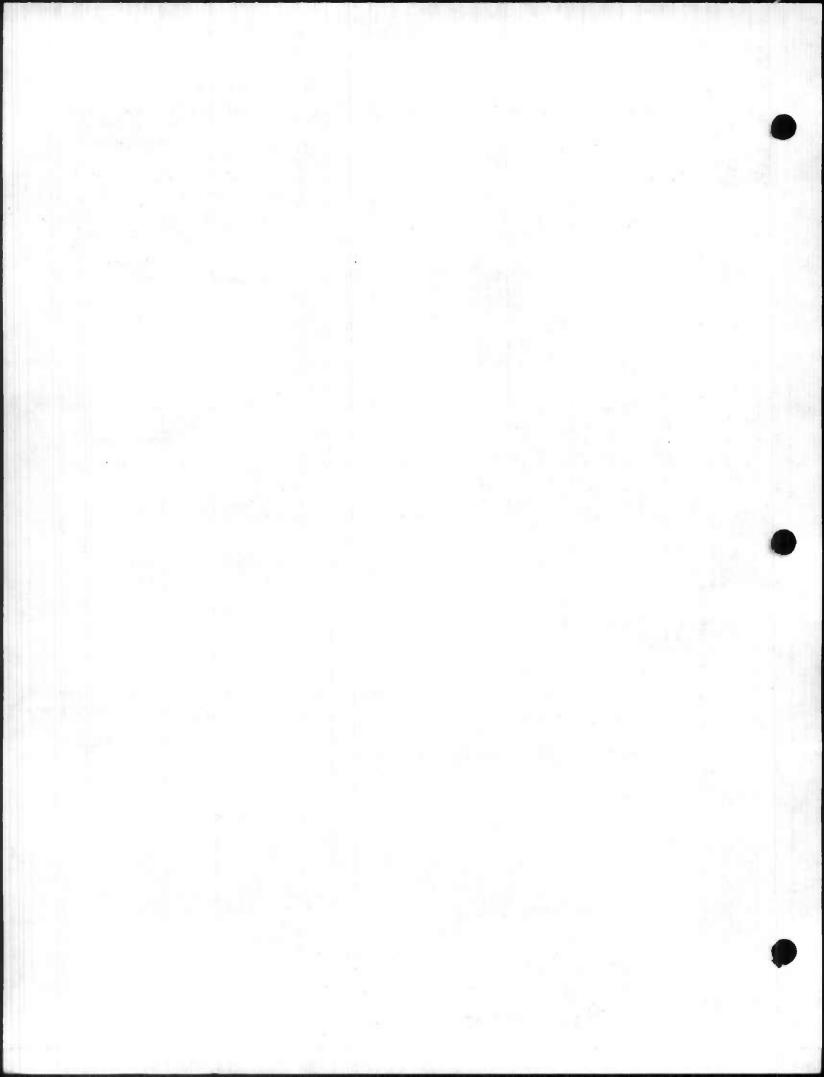
State Registrar 29b. Signatura and titla of certifiar

Dr. Pickert 180 Thomas Johnson Drive, Frederick, MD 31. Data filed (Month, Day, Year) 32. Registreds Signatura 3 1 2000

30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print)

29c. License number

29d. Data signed (Month, Day, Year) ~00



State of Maryland / Department of Health and Mental Hygiene 1 1533

ysician Medical caminer	4a Facility Name (rginia M If not institution, gh and Aven	erritt	umber)				4h Cihr To	www.oslo		y 23,		3. Time of Deet 8:00am	
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dfed at			Sex 1 D M 2 F	7. Age (In	(In yrs. last birthdey)		Days		Min. Sete of I		Birth 9. Bi		rthplace (State or Foreign Country)	
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Ted I		15. Decedent's E	ducation		16a. De	ecedent's Usi	uel Occu	pation			16b. Kind of			
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BeC	17. Father's Neme	(First, Middle, Last)					18. Moth	er's Neme	(First, Middle	, Meiden Sum	eme)		
	W	lliam Lo	ng	ıg						e Wil	liams	.ams		
		ame/Relationship		(Son)		-		Street end Number or Rural Route Number, City or Town, State, Zip Coglake Way North, Sykesville, MD						
		position Cremation 3 [5 Other (Speci	Ob. Placa of D cametery, Druid	cremetory or	other ple	,		Jan 28	20c. Location					
once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, interval Between Interval Be													
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Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate	of	Death		F	Reg. No.			
Dhueis		1. Decedent's Nama (First, Middle, Last) 2. Dete of Daeth Month Day Year											Yaar	3. Time of Death	
Physic /Med		Paul F. Murphy									Januar	*			
Exami		Fairhaven (7200 Third Avenue)									ille	4c. County of Death Carroll			
Funeral Director		5. Social Security N 014-14-8		6. Sax 1 M 2 □ F						4 Hrs. 8 Min.	Data of Birth Month, Day July 5	1922	place (State or Foreign Mass.		
pu .		Usuel Rasidanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location												Od. Insida City Limits	
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th with 23a or		10e. Street and Nu 37 Fox	mber Hill R	oad			10f. Zip C		1545			10g. Citizen of US		itry?	
- P - E	by Funeral	11. Marital Status 1 Never Marr 3 Widowed		Armed F ad 1 1 2 Yas If Yas, G	Armed Forces?			Was Decedant of Hispanic Origin? (Specify Yas or It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No Specify:					or No- 14. Race - Amarican India Black, Whita, atc. Specify: White		
121 within	Be Completed	(Spec		t grade completed	pleted) ollaga (1-4or 5+) 4 16a. Decedent's Usuel Occupat (Give kind of work done at life. Do NOT use retired) Executive Ad							16b. Kind of B	usiness/ind	dustry	
be file that the double overt	To Be C	17. Fathar's Neme John		s Murphy							First, Middle, abeth	Maiden Suman Doyle	ne)		
		19a. Informant's Name/Ralationship (Type, Print) Mr. John Murphy (Son) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, 215 Georgetown Road Annapolis, MD 21403												Code)	
0 -755		20e. Mathod of Disposition 1 Burial 2 X Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Serv. 1/29/2000 Sykesvi													
Baltimor pemit, Pages Department of I important: If its any injury or of		21. Signetura of Fu	21. Signetura of Funerel Sarvice Licensee Alarge 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400												
		23a. Pert1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
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Registrar

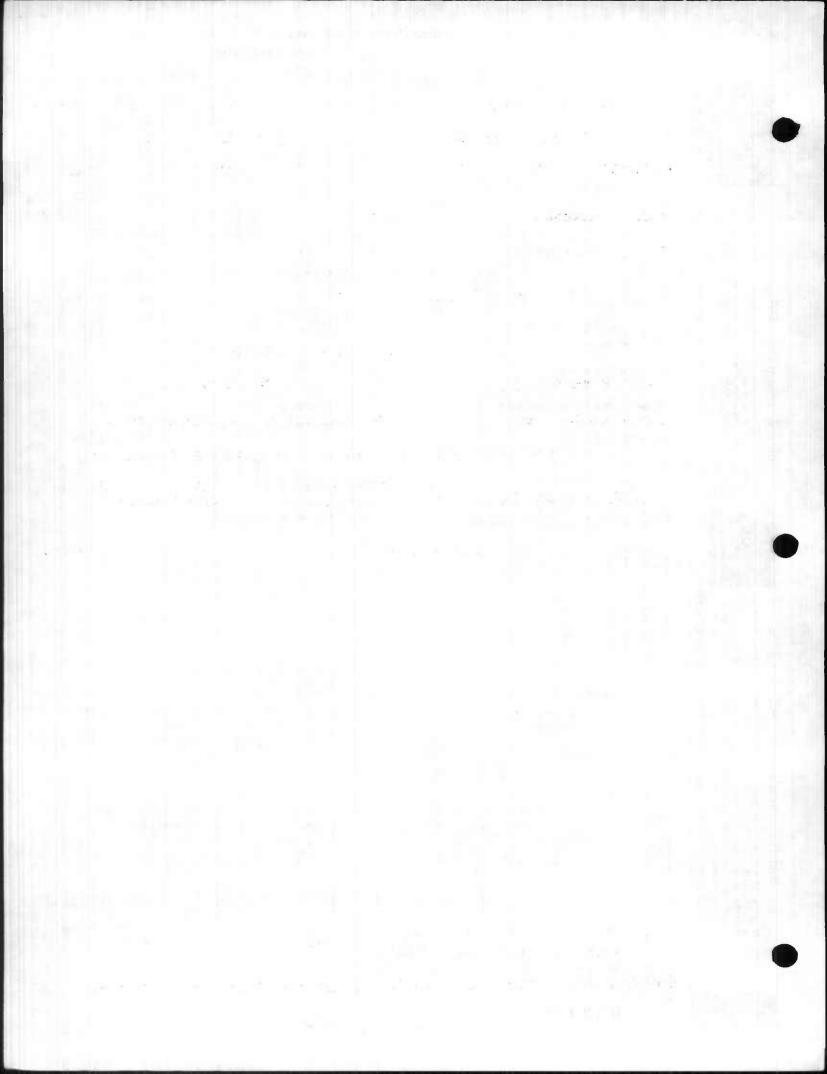
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31. Data tiled (Month, Day, Year)

JAN 3 1 2000

32. Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 01/31/2000 State of Maryland / Department of Health and Mental Hygiene Amend Item 19a per F.D. Amend Items 29c & 31 per Carroll County, wjl Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** RICHARD GOHR MAGRUDER, SR. 27, 2000 3:00 pm January /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner 2A Reisterstown Baltimore Sesame Ct. Apt If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Ser 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours Min 1√2√M 2□ F Yrs. Director 219-14-8470 Jun 25 Usual Residence of Decedent the Maryland r 28a-f show increffed at 10e. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 ☑ No Baltimore Reisterstown Director MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with I r than "natural", or items 23s or the Medical Examiner must be r permit. Pages 1 and 2 should be filed within 72 hours after deeth v
Department of Health and Mentel Hygiene "natural", or itema 23a
any Injury or other treumatic event, the Medical Examples 23a
any Injury or other treumatic event, the Medical Examples 23a
any Injury or other treumatic event, the Medical Examples 23a 21136 1 Sesame Ct Apt 2A IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Maritel Status Bleck, White, etc. 1 Nes 2 No 1941 If Yes, Give Yeer or Detes: 1043 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black p 3 Widowed X Divorced 1943 Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Western Maryland Elementery/Secondery (0-12) College (1-4or 5+) Custodian/Carpenter College 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Bertha Murdock Albert George Magruder 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

1 Sesame Court Apt 2A 190. Mariene Magruder daughter Apt 2A 21136 Richard Reisterstown, MD 20b. Pleca of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removel from State 2/4/20 Parrison, MD 4 □ Donetion 5 □ Other (Specify) Veterans Cemetery MD m of Funerel Service Licensee 22. Name and Address of Fecility Pritts Funeral Home and Chapel, P.A. MD 21157 412 Washington Rd. Westminster, #12 Washington Rd. Westm to disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MON THS PANCREATIC CANCER **Examiner** Due to (or es a consequence of) Examiner physician and the buriel-transit the deeth certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting In deeth) Lest Due to (or es e consequença of): P.O. Box 68760. Physician/Medical Due to (or es e consequenca of): 88 9SD signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, p 24b. Were eutopsy findings avellable prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) O_L 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menger of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Meturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident ofter deat Director: To the Hospital or Atter within 24 hours effer dea To the Funeral Director completaly filled in by th 6 Could not be determined 3 Sulcide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e, Certifier edical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) P12440

State Registrar 31. Dete filed (Month, Day, Year)

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ARIEL

22 32. Registrer's Signeture JAN 3 1 2000

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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) UNIVERSITY

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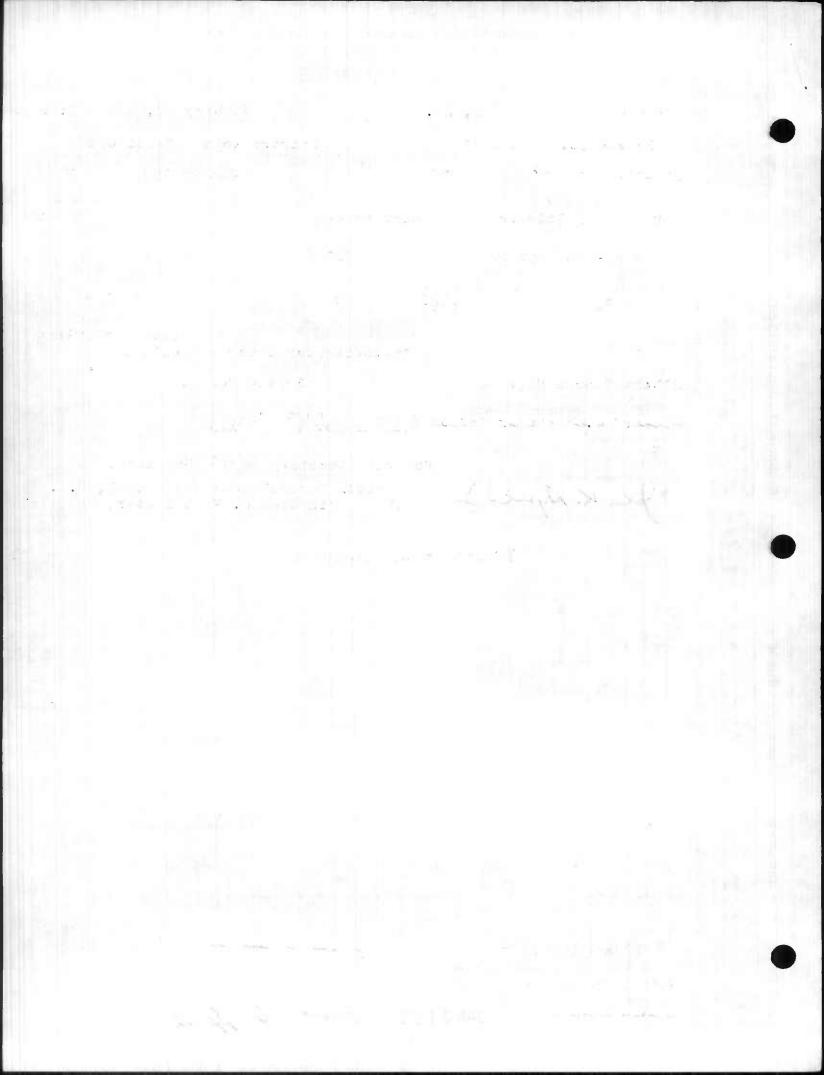
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OF MARYLAND HOSPITAL

28

2000

BALTIMORE, MD 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** LUTHER MILLS 625 25,2000 4b. City, Town, or Location of Death 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 719-01-3961 87 12-6-1912 KENTUCKY Director Usuel Residence of Decedent 10a. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 ☐ Yes 2X No Director 28a-f DELAWARE SUSSEX FRANKFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? therm 23a or b RT.#1 BOX 18 19945 U.S.A. Funeral 11 Merital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. the Medical Examiner 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 X Married 1 Yes 2 No Specify: WHITE Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elamentery/Secondery (0-12) College (1-4or 5+) 8 CARPENTER/PLUMBER HOUSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental MART MILLS CATHERINE HINKLE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOBBY MILLS/SON Bern 27 RT.1 BOX 18, FRANKFORD, DELAWARE. 19945 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremation 3 Removel from Stete = b 4 ☐ Donation _ 5 ☐ Other (Specify) MILLS CEMETERY 1030-00 TURKEY CREEK, KY. 21. Signature of Funeral Service Licenses 22. Neme and Address of Facility MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST, FRANKFORD, DELAWARE. duest e, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, fellura. List only one cause on each line. Approximata Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disaese or condition resulting in death) Remonie Days Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): physician s the buriel Physician/Medicai Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown heart failure should be det þ Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? e-oschoti cardiovascular discose completion of causa of death? page 2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Menger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h. Time of 28c. Injury at Work? Affer 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

0 State

Registrar

completely

STEPHAN 31. Data filed (Month, Day, Year) FEB 0 2 2000

29b. Signature and tible of certifie

(Check only one)

32. Registrar's Signature

m. O.

m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAULOS

400 EASTERN SHOLE DI

29c. License number

D41721

29d. Data signed (Month, Day, Year)

28

2000

JANUARU

SAUISBUM

wether Mills

Baltimore, Maryland

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

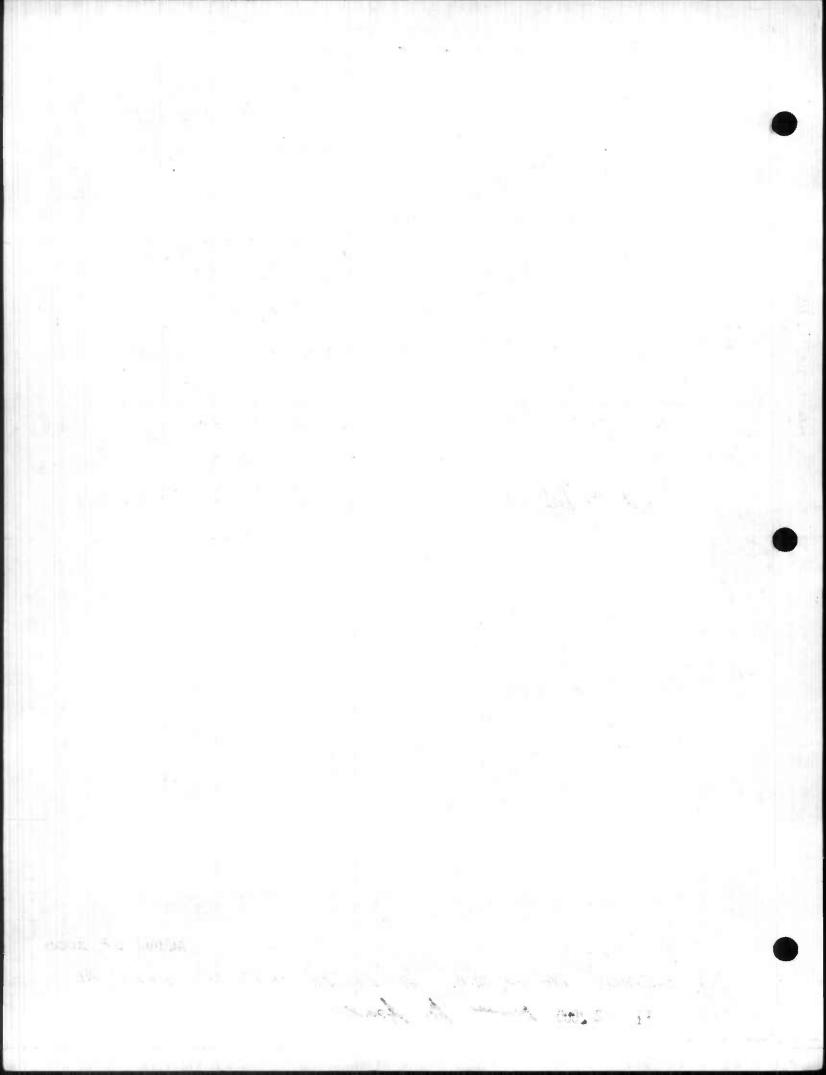
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or Attending Physician:

Hospital

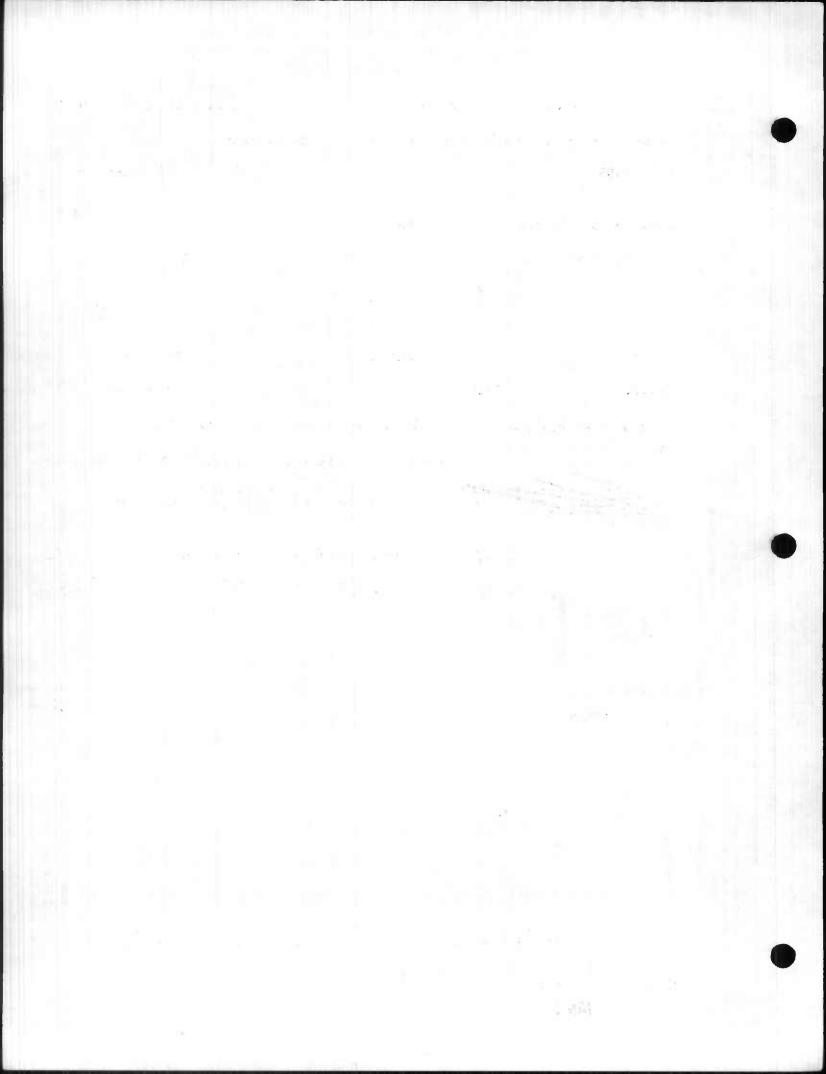
within 2 To the



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State of Maryland / Department of Health and Mental Hygiene 00 04537

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Baltimore,	permit. Paga: Departmant of Important: If i any injury or once.		21. Signature of Funeral Employ Lice	nsge			Neme end Addre			1 II.			
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Division	or A star Direction by	Certification:	4 ☐ Homicide determined	building, etc	. (Specify,)	ot, factory, office			City or Town			
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signeture end title of certifier	end manner ste	www.		29c. Licens	se number		2	9d. Date signe	d (Month	Day, Year)
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			Heleri Noble M		1.		Suit #.	s, Che	ster	town,	md. Z.	1620	
	Sta		31. Dete filed (Month, Dey, Year)	7 2000 Negistre	r's Signet	ure And	4 1			•			
	Registr	ar	Unit &	1 4000		1	N. B.	But In 1					



Box 68760 P.O. Records,

altimore, Maryland 21215-0020

that the death certificate be axecuted Division of Vital or Attending Physician:

To the Hospital or within 24 hours aft To the Funeral Di completely filled In

2+1

edicai

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signature and the of out the

29c. License number

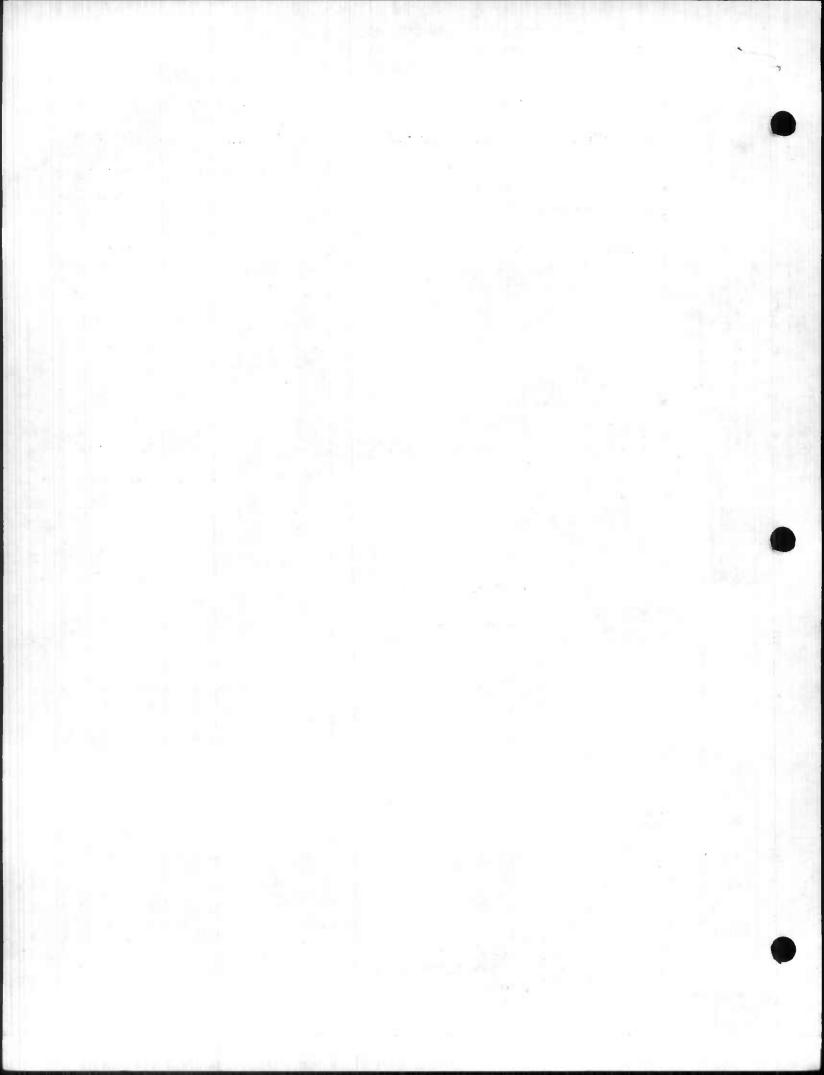
29d. Date signed (Month, Day, Year) 00

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

9715 MEDICAL CENTER DA., ROCKVILLE, MD 20850 RIMARSHALL ACKERMAN, MID. 31. Date filed (Month, Day, Year)

State Registrar

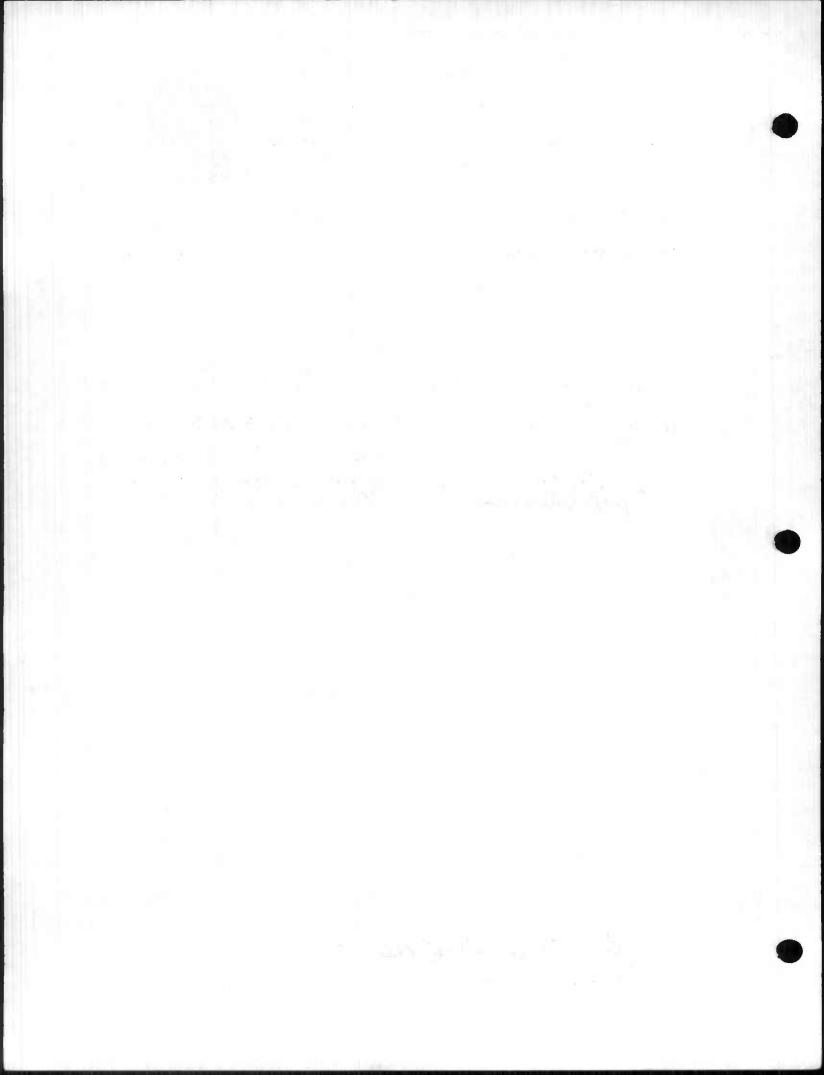
FEB 1 2000 32. Registrar's Signature 12 person



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State of Maryland / Department of Health and Mental Hygiene 11 15 3 9

Usual Residence of Decedent 10a. Stata 10b. County Maryland 10e. Street end Number 10201 Grosvenor Place, #1	ge (In yrs. last bir 87 10c. City, Town 118 t Ever In U.S.	hthday) If Under 1 Year Months Days n or Location Ro C	Hours Min. kville	8. Data of Birth (Month, Day, June 3,	Day 2.7 4c. County M.	Year 2000 2 of Death Ontgome 9. Birthplaca Country) Alaba	(State or Foreign					
/Medical Examiner 4a. Facility Name (If not institution, give street and number, Casey House Hospice Funeral Director 5. Social Sacurity Number 6. Sex 1 M 2015 7. April 1	ge (In yrs. last bir 87 10c. City, Town 118 t Ever In U.S.	thday) If Under 1 Year Yrs. Months Days n or Location Ro c 10f. Zip Code 2	Rockville If Under 24 Hrs. Hours Min. kville	January ocation of Death 8. Data of Birth (Month, Day, June 3,	27 4c. County M Year) 1912	2000 2 of Death ontgome 9. Birthplaca Country) Alaba	ery (State or Foreign ama Inside City Limits					
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15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation	ine	16b. Kind of Bu	usiness/Industr	ry					
3 Widowed 4 Divorcad Ff Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 5+	5+)		d) most or work	ng								
N \$555 5 5+		Teacher			Educat							
17. Father's Name (First, Middle, Last)	T - + + 1 -		18. Mother's Name		-	10)						
Joseph Roberts 19a. Informant's Name/Relationship (Type, Print)	Little	Mailing Address (Charles		Ennis al Route Number, City or Town, State, Zip Code)								
Raymond L. Mazza / Son		238 Dungann										
20e. Method of Disposition	20b. Place of	Disposition (Name of ry, crematory or other pla		Date	20c. Location -							
O 50 = 5	4		P	anuary 29,2000	C41	Cantac	MD					
20e. Method of Disposition 1												
MARK & Holinian	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate T. A. 933 Gist Ave., Silver Spring, MD 20910											
Physician /Medicai Immediate Cause (Final disease or condition	shock, or heert feilure. List only one cause on each line. Immediate Cause (Final											
resuming in death)	Due to (or as a consequence of):											
Mycob	acterium	n Avium										
b. Mycob Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events reaulting in death) Last												
reaulting in death) Last The death conditions contributing to death by the state of the second state of t												
• D & Y Part II. Other eignificant conditions contributing to death b	but not resulting Ir	the underlying cause given	ven in Pert I.	23b. Did to	bacco use co	ntribute to the	cause of death?					
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The second secon	ient 2 ER/Ou	tpatient 3L DOA		me 5 Reside			Hospice					
27. Manner of Death 1	ay Year)	Fime of 28c. Injury Wor	rk? Yes 2 □ No	28d. Describe ho	w injury occur	red						
1 Metural 5 Pending (Month, De la	niuny - At home fa	rm, street, factory, office		28f. Location (St.	reet and Numb	er or Rural Ro	ute Number					
28a. Date of Injunction of the property of the	tc. (Specify)	iii, street, factory, omos		City or Town		or or rear re	oto manipor,					
29e. Certifier (Check only) 29e. Certifier (Check only) (Check only) (Check only) (Check only)	of examinetion en	, death occurred at the tir d/or investigation, in my o	me, date and place, a pinlon, deeth occurr	and due to the ce	ouse(s) end me ate and place,	enner as stated end due to tha	d. cause(s)					
and manner st	tatou.	29c. Licans	a number	29	9d. Date signe	d (Month, Dey,	Year)					
	·for	MA D09	470			ry 28,2						
30. Name end address of person who completed cause of c	death (Item 23a) (Type, Print)				,,,						
Eugene P. Libre M.D., 104			, Kensing	ton, MD	20895							
State Registrar FEB 1 2000 32. Registrar	trar's Signature	9. Sports										

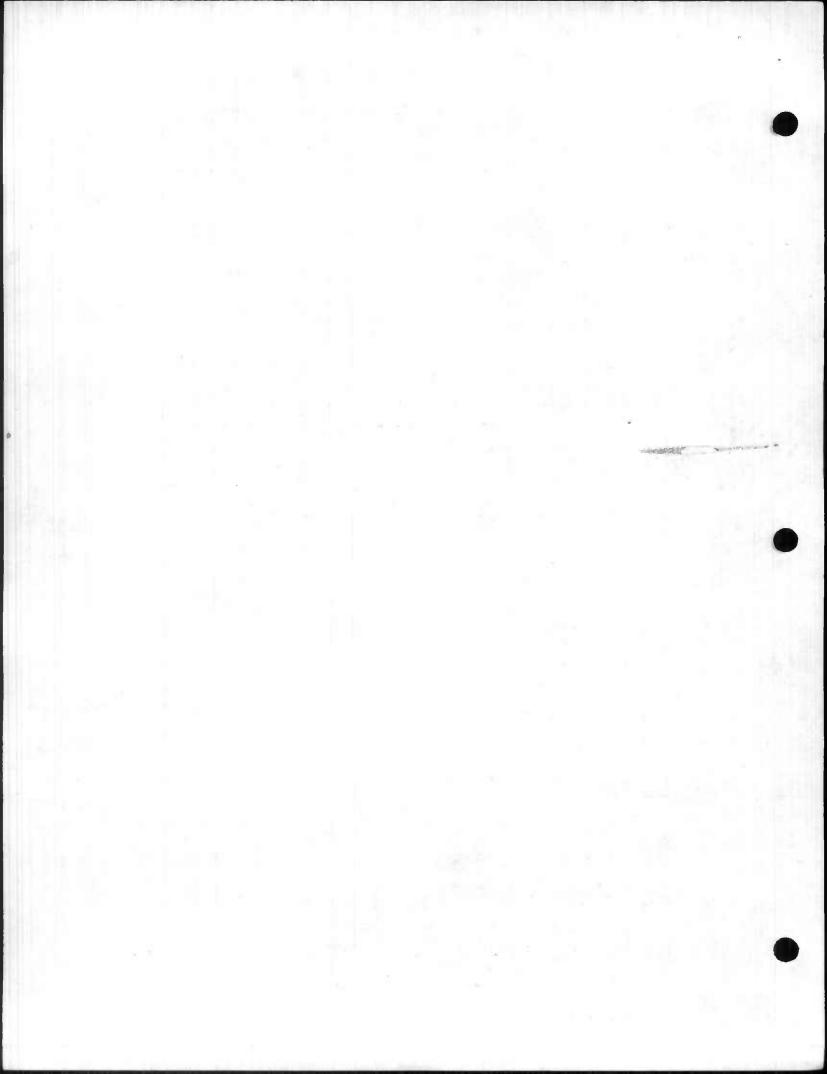


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #23a-I, II, 2/4/2000, BMW, Montg. Co. Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month **Physician** 9:35 PM 2000 THomas MCANALLO 27 JAN /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Dete of Birth (Month, Day, Year) H Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Hours Months 12 M 2 F Yrs. Director 217-30-6814 Jan. 31, 1934 65 Washington, D.C. Usual Rasidence of Decedent with the Maryland 10s. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director 28e-f Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? mant be Funeral 15403 Short Ridge Court, Mutual 20906 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11 Maritei Stetus Bleck, White, etc. than "natural", or lise the Medical Examiner Pages 1 and 2 should be filed within 72 hours after that of Health and Mental Hygiene, surt of Health and Mental Hygiene, surt if them 27 is mericed other than "natural", or its under the mental to event, the Medical Examines ury or other treament event, the Medical Examines 1X Yes 2 No If Yes, Give 1957 Yeer or Detes: 19 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: À 3 ☐ Widowed 4 ☐ Divorced 1959 White Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Federal Government Accountant 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) Be 2 Martin McAnallen Ruby Mevers 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 195. Maning Address (Street and Number of Hural House Number, Cry of 1 15403 Short Ridge Court, Mutual 15 Silver Spring, Maryland 20906

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Local (wife) Lucia McAnallen 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Jan.30 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 2000 Alexandria, Virginia 21 Signature of Funeral Service Licenses 22. Neme and Address of Facility Francis J. Collins Funeral Home, Inc. amo 500 University Blvd., West, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart feiture. List only one cause on each line. Approximate Intervei Between Onset and Death **Physician** /Medical Immediate Causa (Final Acute Room diseese or condition rasulting in death) wach Examiner Due to (or as a consequence of) Congestive Heart Failure The law requires that the death certificata be executed the burial-transit Sequentially list conditione, if any, laading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): and Box 68760. Physician/Medical Due to (or as a consequence of) detached for use as Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown MIWI 4 ģ Division of Vital Records, 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen has page 2 2 No certificate MY 600 0937 basine SHUTTOM'S 1 □ Yes 2 □ No or Attanding Physician: funeral director. 25. Was case raferred to medical examiner? Be 26. Place of Deeth (Check only ona) Hospital: 1 pnpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 2 No this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Daturel after death. 1 ☐ Yes 2 ☐ No 2 Accident n 24 hours after des re Funeral Director pletely filled in by th 6 Could not be datamined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, lerm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, data end place, and due to the cause(s) and menner steted. To the I within 2 29b. Signature and titla of dertifier 29c. License number 29d. Date signed (Month, Day, Year) +1 10 30. Namerand address of person who completed cause of death (Item 23a) (Type, Print) BOCKIA 4707 h 17 Center 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State FEB 04 2000 Registrar

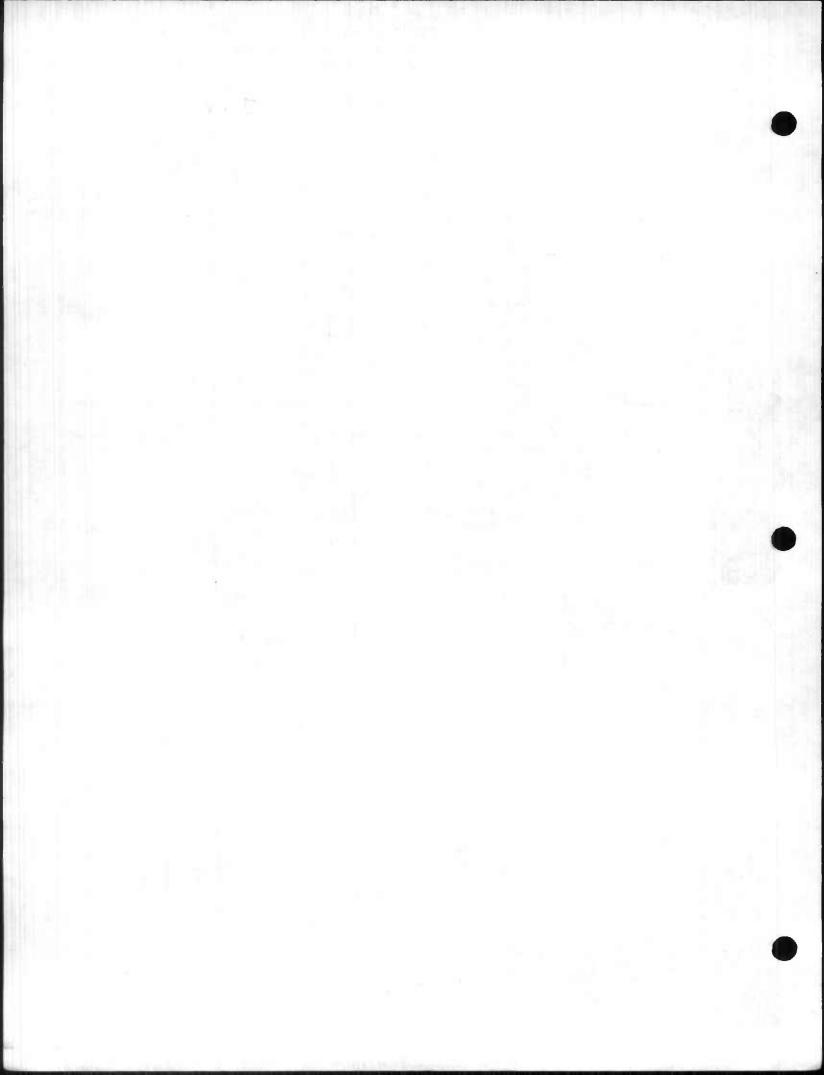


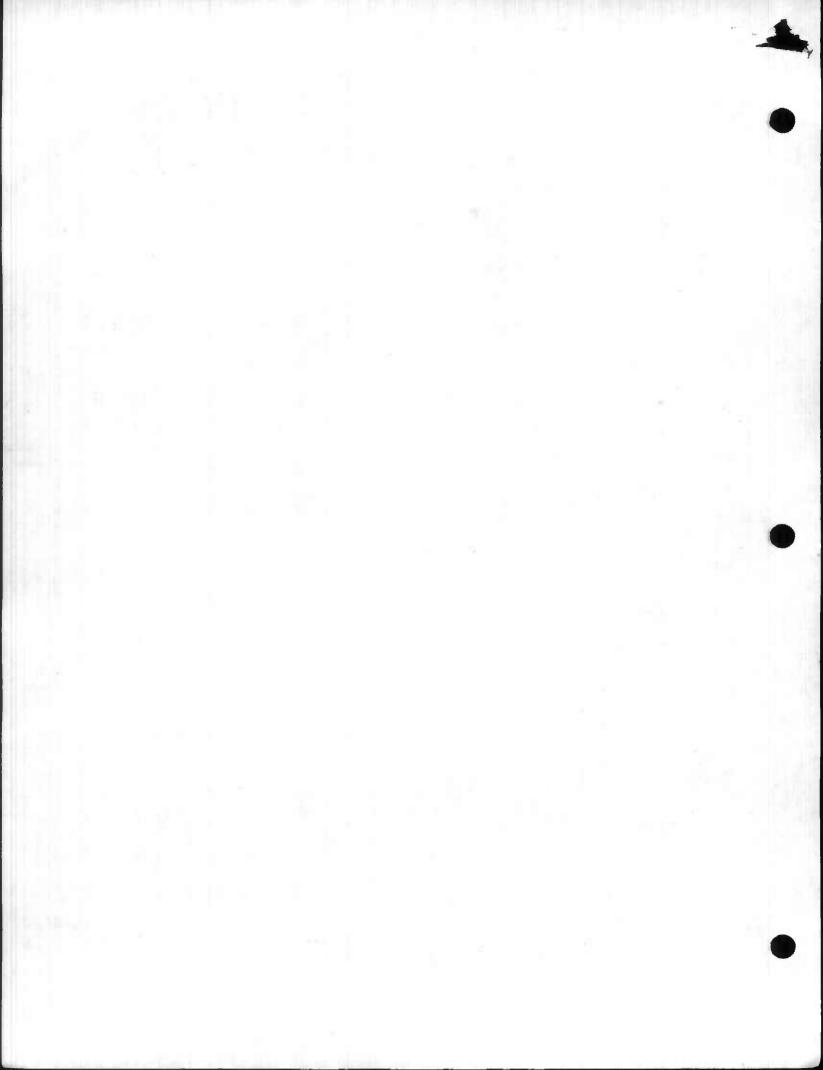
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 805 AM Month MCCONNEL **Physician** Margaret 30 2000 aN. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 13, 1901 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Days Hours Months 98 Aug Director 213-48-0121 Usual Residence of Decedent deeth with the Maryland 10b. County 10c. City, Town or Location ahow 10d Inside City Limits than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20783 USA Funeral 2261 Lewisdale Drive Wes Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No 21215-0020 Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Own Home Homemaker poemit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, important: If fleen Z7 la marked other any injury or other transmitted other. Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Margaret Mahoney James V. Beyer 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2261 Lewisdale Drive, Hyattsville, MD 20783 John J. McConnell/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ABuriel 2 Cremetion 3 Removel from Stete 2/2/00 Suitland, MD Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart feiture. List only one cause on each line. Approximate Intervei Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel NEUMONIA disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be asscuted use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Be Completed 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? certificate 1 ☐ Yes 2 ☐ No after death.

Director: After this certifica the funeral director, 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Neture 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29e. Certifies 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28267 2000 10 SUSAN VANSSIMID. who completed cause of death (Item 23a) (Type, Print) Md. 20705 Illiea itsville 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 2000 Registrar





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Olympia Marie Merletti January 28, 2000 10:30 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meridian Spa Creek Nursing Home Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) 1□ M 2XX Days Months 192-05-2975 86 Feb. 11, 1913 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 35 Milkshake Lane 21403 United States 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Merital Stetus 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elia Migliore Consiglia DeLucia 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lewis Merletti Son 6205 Diana Court, Highland Heights, Ohio 44143 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 2/3/00 Penn Hills, PA Mt. Carmel Cemetery 4 Donation 5 Other (Specify) 21. Signature) of Funerel Service Licenses 22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street, Alexandria, VA 22310 and anti-enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart feiture. List only one cause on each line. Interval Between Onset and Death Immediete Cause (Final 6 hearty disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) years Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? No No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 200No Hospital: 1 | Inpatient 2 | ER/Outpatlent 3 | DOA Other: | Nursing Home 5 | Residence 6 | Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (2Netural 5 Pending 1 Tyes 2 No investigetion 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

burial-transit The lew requires that the death certificate be executed pue physician s the buria Box 68760. 88 987 P.O. signed by it Division of Vitai Records. page 2 certificate or Attending Physician: funeral director. this After

Medical Certification: To

Physician/Medical

Physician

/Medical

Examiner

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Item 27

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efter deeth. Director: Aft in by filled ! 24 hours e Hospital To the Hosp within 24 hor To the Fune completely fi

> State Registrar

29b. Signature and title of certifier

FEB 03 2000

H.P.

29c. License number D40519

Glen Burnie, MD

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mirza Nufairee, MD 795 Aquahart Road

31. Date filed (Month, Dey, Year)

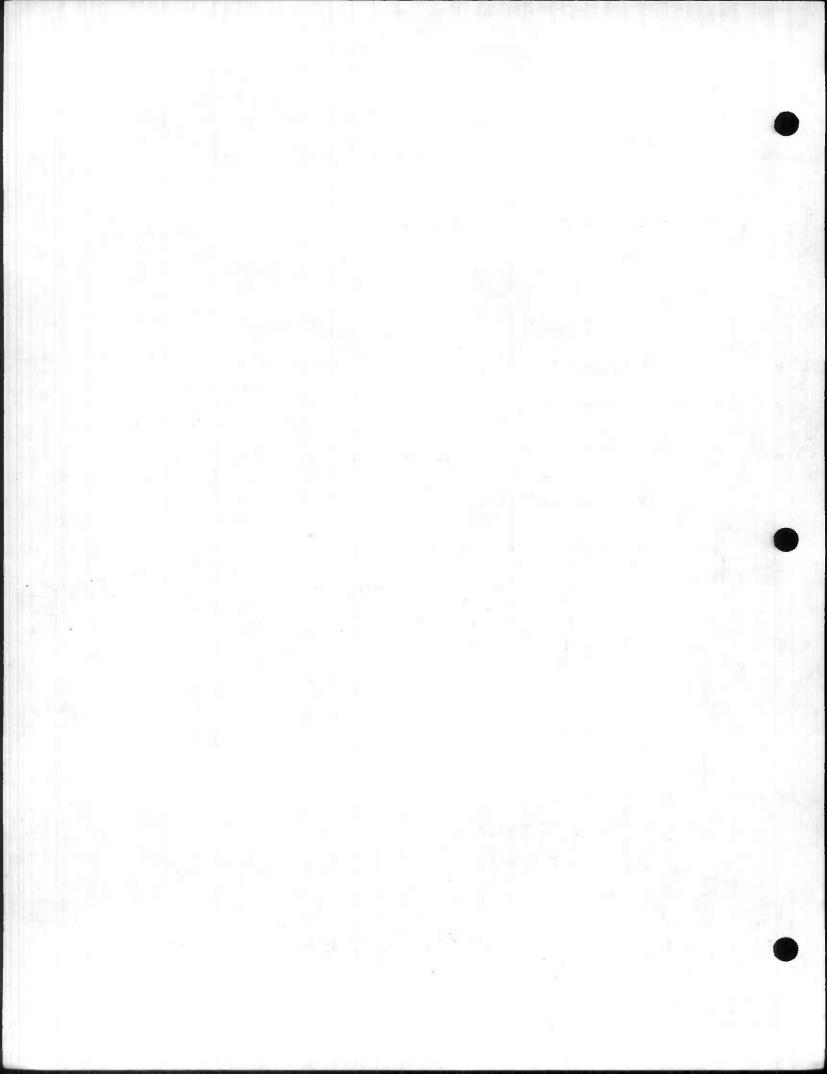
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(Check only one)

29a. Certifier

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Year **Physician** 0635 Tra31er George Seb 2000 /Medical 4a Fecility Name (Unot Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 5 182010 Silver 1ane Danco If Under Months ar If Under 24 Hrs. s Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 578-52-5204 1928 Sep 16, New Jersey Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r 28a-f show 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or frame 23s or the Medical Examiner must be 4013 Peppertree Lane 20906 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, Whita, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 XNo Specify: American by 3 ☐ Widowed 4 ☐ Divorced Indian Completed 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t. Pages 1 and 2 should be filed within 7 timent of Health and Mental Hygiene. Internt: if flem 27 is marked other than "rightry or other traumatic event, ma hear injury or other traumatic event, ma hear in the state of the content traumatic event, ma hear in the state of the content traumatic event, ma hear in the state of the content traumatic event, ma hear in the state of the content traumatic event, ma hear in the state of the content traumatic event, ma hear in the state of the content traumatic event, make the state of the content traumatic event. Bureau of Elementery/Secondary (0-12) College (1-4or 5+) Physicist Printing & Engraving Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be George Frazier Miller Jr. Bertha Williams 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 4013 Peppertree Lane, Silver Spring, MD 20906 Therese R. Miller/ Wife 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place) Data 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If any injury or once 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/3/00 Alexandria, VA 21. Signeture of Funerel Service Licensee 22. Neme and Address of Fecility Collins Funeral Home, Inc. Francis J. Ken Skiles 500 University Blvd., W. Silver Spring, MD 20901 23a. Pan1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner WO U Due to (or as a consequence ot): Examiner The law requires that the death certificate be executed Sequentially fist conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as e consequence ot) Box 68760. Completed by Physician/Medical the Due to (or as a consequence of): for use as P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown of VItal Records, 24b. Were autopsy findings aveilable prior to completion of causa of death? 24a. Was an autopsy performed? certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner?

1 ≥ Yes 2 □ No Certification: To Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28b. Time of Injury 0 6 4 4 M 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After t Division 5 Pending investigation 1 Netural death. 1 ☐ Yes 2 No 3,2000 To the Hospital or Attendi within 24 hours after death To the Funeral Director; A completely filled in by the fi 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 40/3 4 Homicide ppertiet 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piace, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piace, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 10 m 11mE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Licol

State Registrar 31. Date filed (Month, Day, Year)

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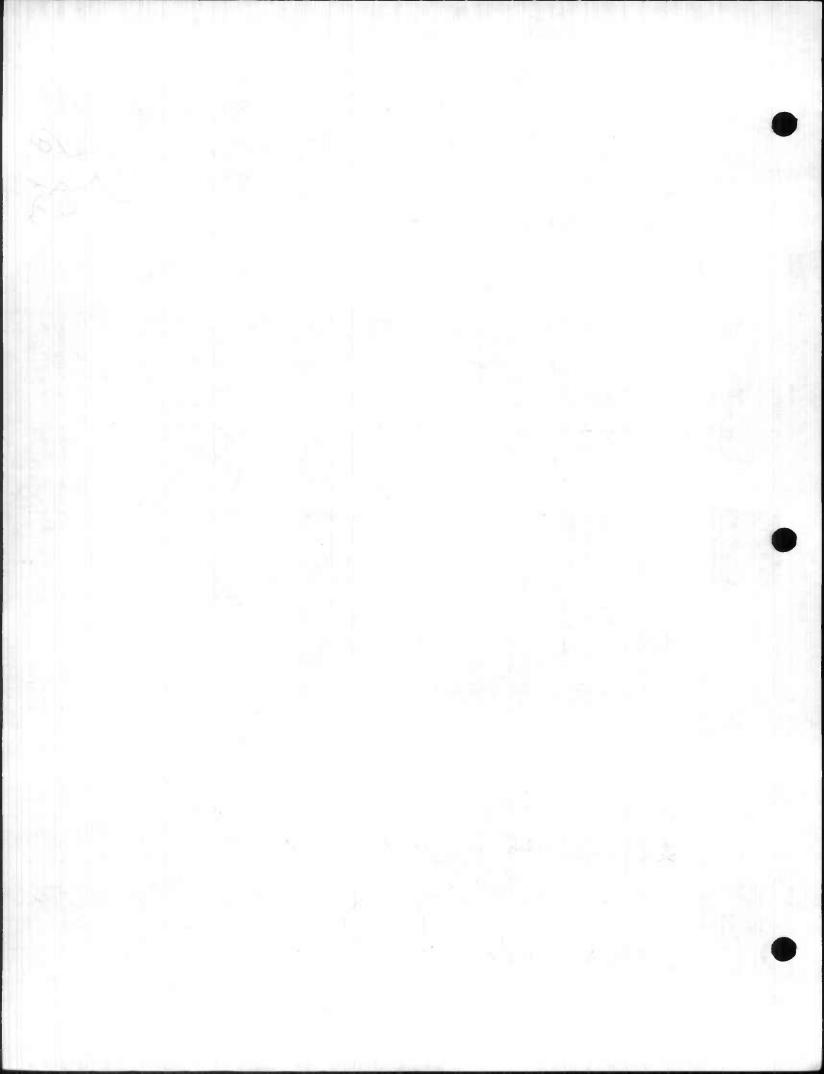
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32. Registrar's Signeture

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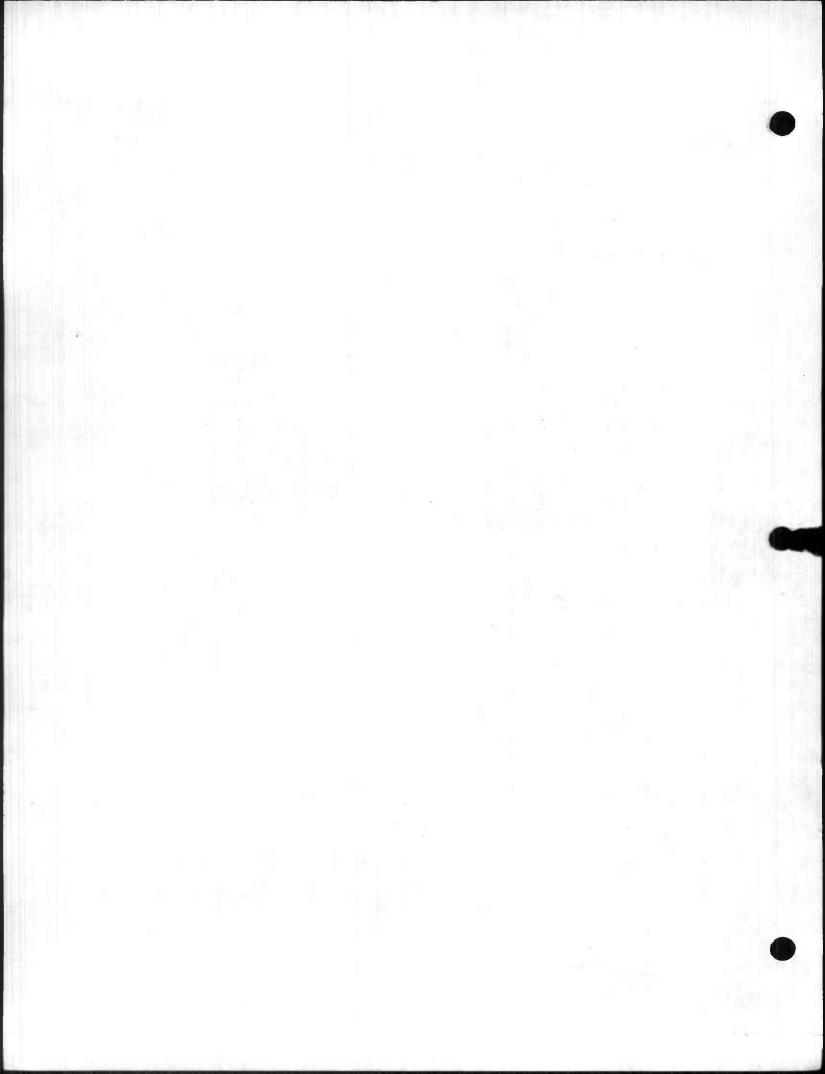
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 1408 pm 25 2000 Tanuara Sara Probst Miller /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□ M 2\ F 190-05-1620 82 Feb. 22, 1917 Pennsylvania Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limita the Marylan Show 1 ☐ Yas 2 No Maryland | Montgomery Director Rockville 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ð munt be Nerns 23a 11400 Luxmanor Road 20852 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, atc. 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: filed within 72 hours after 1 ☐ Never Married 2 Merried 'natural', or 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Office Equipment/ Hygiera. Elementary/Secondary (0-12) College (1-4or 5+) Supplies 12 Owner/Manager important: if lism 27 is marked. Hy any injury or other 27 is marked. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 89 20 George Gresham Porter Wealthy Marie Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informant's Name/Relationship (Type, Print) Sally P. Baer/Daughter 311 Tschiffely Square Road, Gaithersburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb 3 20c. Location - City or Town, State 1 ☐ Burlal 2 M Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervei Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician the burial ereb Physician/Medical Due to (or as a consequence of) USB signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 No þ 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 : 2 No 1 Yea 1 ☐ Yes 2 ☐ No Be 25. Was case reterred to medical axaminer? 26. Place of Death (Check only one) Hospitai: 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of injury / (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

 Birthplace (State or Foreign Country) Baltimore, Maryland 21215-0020 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 Unknown Records, Division of Vital or Attending Physician: Certification: To death. n 24 hours after death le Funeral Director: A pletely filled in by the f 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide Hospital Medical Examiner: On the basis of examination and/or investigation in any original and due to the cause(s) and mannar as stated. 29a. Certifier Medical completely Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title at 6 00 30. Nama and addr e ot death (Item 23a) (Type, Print) 11110 MEDICAL CAMPUS RAS M.B Begistrar's Signature State

Registrar



Please () A or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year MOLNAIZ JO-ANN YANUA124 31 2000 1:20 4.4 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL HOPKING JOHNS BALTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1□M 2⊠F 137-52-0059 45 NOV. 4, 1954 NEW JERSEY Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 NORTHWEST DRIVE 20901 UNITED STATES 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 K Never Merried 2 ☐ Married 1 Yes 2X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementery/Secondary (0-12) LEGAL RESEARCHER FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HELEN KOVACS JOSEPH STEPHEN MOLNAR 19a, informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN MOLNAR - MOTHER 321 NORTHWEST DRIVE, SILVER SPRING, MD 20901 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) GEORGE WASHINGTON MEM. CEM. 2-5-QO PARAMUS, NEW JERSEY 21. Signature of Funerel Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert feilure. Est only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel MENINGITIS NEONNA diseese or condition resulting in deeth) Due to (or as a consequence of): C HISLAND MA WENTAST ASES TIEARS Due to (or as a consequence of): to u'uir AND LYMPH NODES Due to (or as a consequence of): CELBIBAL PALSY UNKINOUN 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examine

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page 2 s

funeral

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Medical Certification: To

The law requires that the death certificate be executed

Physician:

or Attending

Hospital

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death.

within 24 hours after deat To the Funeral Director:

Box 68760.

P.O.

of Vital Records,

Division

Physician

/Medical

Examiner

Director

Funeral

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Completed

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10a. State

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r than "natural", or item the Medical Example: filed within 72 hours after

I Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Ia marked other any Injury or other traumatic event, I

death with the Maryland

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated exact) Physician/Medical that initieted events resulting in death) Lest þ Completed

Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 27. Menner of Death 5 Pending investigation

28a. Dete of Injury (Month, Day Year) 6 Could not be determined

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

BALLTIMONE.

MD

812192

YANJARY 31 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOOCHION AUE, KAUAUBC

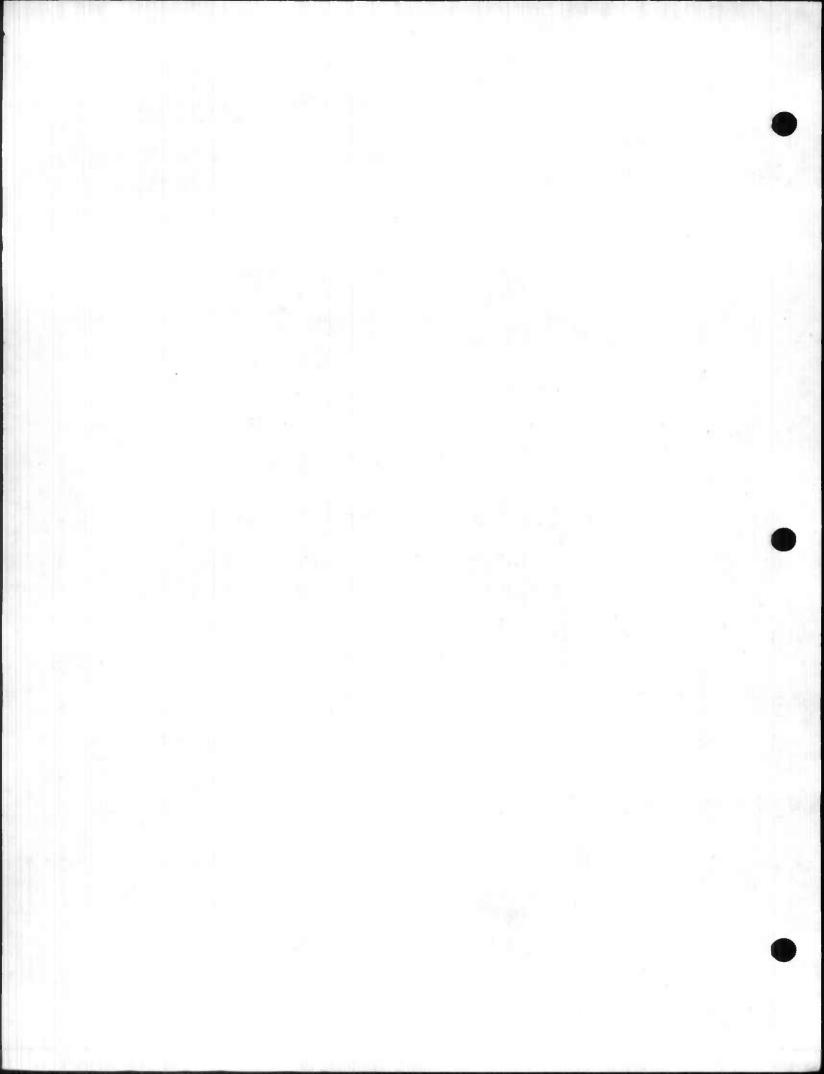
HAKSYMI'LI'AN

31. Date filed (Month, Day, Year)

FEB **04** 2000

32. Registrer's Signature

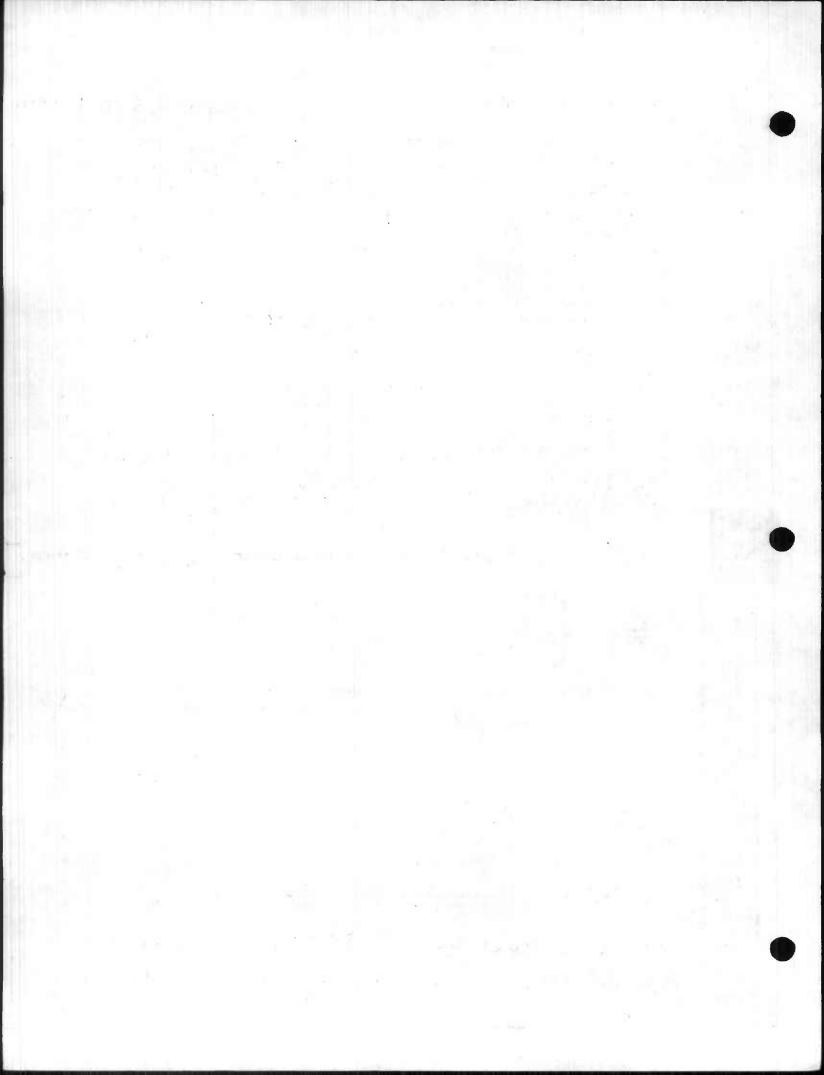
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State of Maryland / Department of Health and Mental Hygiene 0 15517

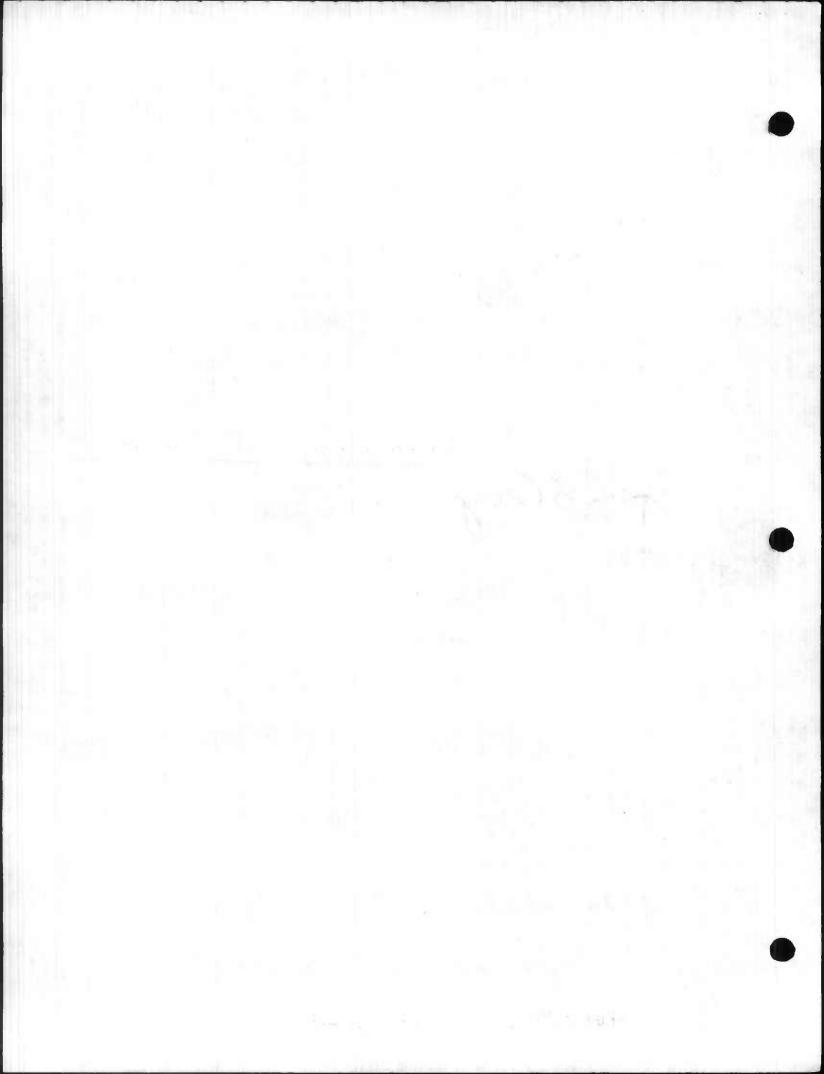
			Ce	rtificate of	Death		Reg. No.		
Physician	1. Decedent's Neme (First, Middle, Las WALTER S.	MOROZ				2. Date of Dea	Day Year	3. Time of Death	
/Medical Examiner	4e Facility Name (If not Institution, give				4b. City, Town, or L	Jan-		0	
Examiner	WASHINGTON ADVENTIST HOSPITAL 4b. City, Town, o						Montgo		
Funeral Director	5. Sociel Security Number 6. Se		rs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.		y, Year) 9. Birt	tholace (State or Forei puntry) nnsylvania	
9	Usual Residence of Decedent	I an	00 7.						
with the Maryland to cr 28a-f show the modified at	Maryland Prince C		City, Town or Lo Seltsvil					10d. Inside City Lim	
ith with the Ma 23a or 28a-fe ust be notified all Director	10e. Street and Number 3006 Chapel View	Drive		10f. Zip Code 20705			United Sta		
urs after dea	11. Merital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? ▼CYes 2 □ No If Yas, Give Yeer or Detes: 1942		Wes Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2XXNo Specify:		pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
et de	15. Decedent's Ed (Specify only highest grad Elamentary/Secondery (0-12)	ucation de completed) College (1-4or 5+)	(Giva kind of work done during most of working			16b. Kind of Business			
Hygiene. Hygiene. ther then ent, the	12	2	Accou	countant			Veterans Administra		
Mental Hygie mrked other artic event, tr	17. Fether's Neme (First, Middle, Last)					e (First, Middle,	Aiddle, Maiden Sumame)		
marked of marked	•		Moro		Rose		CZiokajlo I Route Number, City or Town, State, Zip Code)		
s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other tran-other traumatic event, the Mental Hygiene. To Be Comp	19a. Informant's Name/Retetionship (7 Alice F. Moroz (W			e as #10	t and Number or Ru	ral Route Numbe	r, City or Town, State, a	Zip Code)	
y or I	20e. Method of Disposition XX Burlel 2 Cremation 3 4 Donation 5 Other (Specify	Domovel from State	cemetery, crei	osition (Name of metory or other pla Heaven C		Date 1/28/00	20c. Location - City or Silver Spr		
Department of Important: If any injury or once.	21. Signature of Funerel Service Licen		D 22	2. Neme end Addr onald V.	ess of Facility Borgward	t Funera	al Home, P. sville, Md.	Α.	
physician and s the burial-transit	Sequentially list conditions, if any, taading to immediate causa. Entar Underlying Cause (Disease or injury	b	(or as a consec	- 1/22 =					
5 0 4 -	that initiated events resulting in death) Last Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobs.								
sicis	Part II. Other significant conditions co	ontributing to death but not r	esulting in the u	nderlying cause g	iven in Pert I.	23b. Did 1	obacco use contribute	to the cause of de	
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is been s 2 should pleted							med?	Were autopsy findin available prior to completion of cause of death?	
certificate haractor, page						101		1 ☐ Yes 2 No	
this certific ral director, TO Be (25. Was case referred to medical examiner?	Hospitat Prosting 2	□ ES/Outpution	2 DOA 0	26. Place of Dea				
After fune	27. Mennar of Death 27. Neturat 5 Pending 2 Accident investigation	120 Inpatient 2 LI ER/Outpatient 3 LI DOA 4 LI Nursing Hom					ne 5 Residence 6 Other (Specify) 18d. Describe how injury occurred		
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined					28f. Location (5 City or Tox	Street and Number or R m, State)	ural Route Number,	
within 24 hours and to the Funeral of completely filled in Medical Ce	29e. Certifier (Check only one) Certifying Phy Description one)	rsician: To the best of my k liner: On the basis of exami and manner steted.	nowledge, death nation and/or in	n occurred at the t vestigation, in my	ime, date end place, opinion, deeth occur	and due to the ored et the time,	cause(s) and manner a data and place, and du	s stated. s to the cause(s)	
To the comp	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mon	th, Day, Year)	
10	Marin O.	welton	_	D	53743		1-26-8	000	
·	30. Nama and address of person who co	completed causa of death (It	em 23a) (Type,	Print) CPNW4	en CT D	nu 3	recebelt	- MN	
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrar's Sig	neture 4.	Soon	2		5	0770	



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State of Maryland / Department of Health and Mental Hygiene 🗍 🧍 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year **Physician** WILLER ANUAR D. V. O. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Randallstown Baltimore Northwest Hospital Center If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F 217-05-5817 81 Director April 18, 1918 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Sykesville 1 Yes 2 No Directo Maryland Carroll 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or must be 21784 United States 1438 Fannie Dorsey Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. filed within 72 hours after Yes 21 No 1 ☐ Never Merried 2 TX Married r than "natural", or the Medical Exami Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementary/Secondery (0-12) Weaver Brothers Secretary . Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If Item 27 is merked other th ijury or other traumatic event, Ital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Eva Filbert Charles Reiner t9a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1438 Fannie Dorsey Road Sykesville, MD Leon Miller Husband 20c. Location - City or Town, Stete
Owings Mills, Md
- Pikesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Garrison Forest Vet. Cem. 2/10/00 2/7/2000 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licensee 22. Name and Address of Fecility
Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one cause on eachying Approximate fnterval Between Onset and Death **Physician** PHEUMONIA /Medical Immediate Ceuse (Finei · BILATERAL disease or condition resulting in death) Examiner Physician/Medical Examiner MYDCARDIAL sician and burial-transit NTE or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Box 68760. Due to (or as a consequence of): 65 for use signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed by Division of Vital Records. 24b. Were autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 204 No 1 ☐ Yes 2 ☐ No certificate 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 20 No 1 (Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Matural within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital **SCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end manner stated. 29a. Certifier completaly (Check only one) 2 29c. License number 29b. Signature and title of celtifier 29d. Date signed (Month, Day, Year) mula mo D00 41410 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P MEHTA HUSPITAL RANDAUSTOWN 21133 CENTER MO MORTHWEST 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Benezario Registrar FEB 0 2 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year Physician 7:06 um 2000 68 SEOR46 /Medical Facility Nama (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. Munty of Death Examiner CENTER HEURRIY GEORYES If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days NONE 1 M 2 F Months Hours Director Usual Rasidence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. Court 10c. City, Town or Location ir than "natural", or frame 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director 10f. Zip Code 10a. Street and Number 10g. Citizen of What Country? 902 Will Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yas 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 IACK Specify: 1 Yes 2 10 No Specify. p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired). 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secordary (0-12) College (1-4et 5+) Hygiene. permit. Pages 1 and 2 should be filled with Department of Heelth and Mentel Hygien Important: if hem 21 is marked other the any Injury or other trauments. -N FAN 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be MARIE thony 2 VONNE 19a Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Of tAI nevery, MARYIAND 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c Location - City or To 1 Burial 2 Cremation 3 Remoyal from State 4 Donation 5 Otto Spanish 21. Signature of Funaral Service Licens 22 Name and Address of Facility Part 1. Exercise as a disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, if he art failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last pue Due to (or as a consequence of). physician as the bunel Box 68760. Physician/Medical Due to (or as a consequence of): 80 attending 950 to Part If. Other aignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the 3 1 Yas 2 10 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peed: page 2 1 Yes 2 100 1 Yes 2 No Division of Vitai or Attending Physician; Be 25. Was case rafarred to medicat axaminar? 26. Place of Death (Check only one) Hospital: 1 Yas 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred Certification: : After t t Matural 5 Pending within 24 hours after death. To the Funeral Director: Al invastigation 1 | Yaa 2 | No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital edical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated. (Check only one) miner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifie 29c. License number

State Registrar 30. Name and address of person who

31. Data filed (Month, Day, Year,

DHMH 16 Ray 6/95

Cause of death (Item 23a) (Type, Print)

32. Registrat's Signatura

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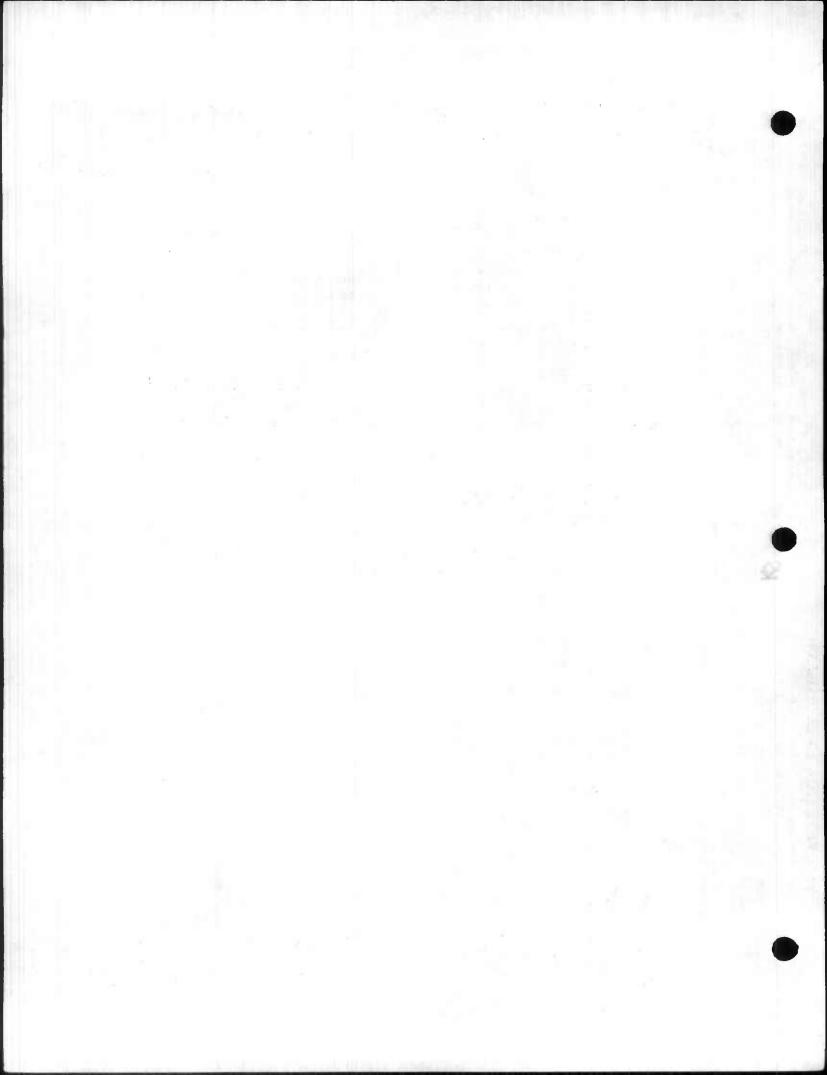
MOORE, ELAINE

EUZABETH

	1 Danadant's Name /Fire	Adiridio I a	nd)		Cer	tificate of	Death	2. Date of D	Reg. No.	3. Time of D			
Physician	Decedent's Nama (First, Middle, Last) Elaine Beard Moore					Month	Day	Year					
/Medical	4a Facility Nema (If not in:			r)			4b. City, Town, o	Januar Location of Dea		2000 0314			
Examiner	Washington					Hagerst	own	,	ington				
Funeral Director	5. Social Security Number 722–12–3855	1	ex □M XXF 7./	Nge (In yrs. la 73	est birthday) Yrs.	Months Days	Hours Mi		hay, Year) 6 1926	9. Birthplece (State or I Country) Washington			
1.	Usual Residence of Deced	dent County		10c. City	. Town or Lo	cation				10d. Inside City			
28a-f sho notified at		rederi	ck		unswic					1 ⊠ Yes 2			
Pects and		edell	CK	DI	unswic				10g. Citizen of V	Whai Country?			
Se or	10e. Street and Number 14 West "I" Street 21716						USA						
af, or larns 23s or 23s-fs Examiner must be notified by Funeral Director	11. Merital Status 1 Never Married 2(3 Widowed 4 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	☐ Merried	12. Was Deceder Armed Forces 1 Yes 20 If Yes, Give Year or Detas	s? ₹No		Ves Decedeni of h Yes, specify Cub		Specify Yes or Norto Rican, etc.)		ce - American findien, ck, White, etc. y: Black			
r, the Medical	15. De (Specify only	ecedent's Ed	lucation de completed)		16a. Deced	lent's Usuel Occup	pation during most of w	orking	16b. Kind of B	usiness/Industry			
d d	Elementary/Secondary (College (1-4o	r 5+)		kind of work done	d)		Homom	a kan			
00			3		Hous	ewife	1 .=		Homem				
Be	17. Father's Name (First, A								e, Maiden Sumen	ne)			
2	Henry A. Bea							Campbel					
Taura Taura	19e. informent's Neme/Re					g Address (Street				, Stete, Zip Code)			
100	Kathryn B. F		Sister	20h Ble		Box 265, sition (Name of	Brunsw	Dete	1	- City or Town, State			
S Amel	1 Donation 5 0	nation 3 ther <i>(Specif</i>)	1)	Ce	metery, cren irview	ratory or other pla I Cemeter	у	/22/00	Frederi				
9000	21. Signature of Filmeral S Barbara	21. Signalure of Fineral Service Lorence 22. Name end Address of Facility John T. Williams 100 Petersville 23a. Pert1. Enlar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cere shock, or heart leilure. List only one cause on each line.						Funeral Road, Br	Home unswick,	MD 21716			
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of or use as			O										
Physic	Part ii. Other significant co	onditions o	ontributing to death	but not resul	lting in the ur	nderlying cause gi	ven in Part f.		tolecco use co	ontribute to the cause of 3 Probably 4 U			
Completed by								24e. We per	s an autopsy formed?	24b. Were autopsy lin evailable prior to completion of car of death?			
COL		/						10	Yes 200 No	1□Yes 2□N			
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10	1 □ Yes □ №		Hospitel: 1 Inpa	tient 2 E	R/Outpatien	i 3□ DOA Oti	her: 4 Nursing	Home 5 ☐ Res	sidence 6 🗆 Oth	ner (Specify)			
	2 Accident	Pending investigation Could not be		jury lay Year)	28b. Time of Injury	M 1	ryat rk? Yes 2 □ No	28d. Describe	how injury occur	rred			
ation	3 ☐ Suicide 6 ☐ □	njury - At hor etc. (Specify)				28f. Location City or To	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)						
Certification													
edicai Certification:	4 ☐ Homicide		iner: On the basis	of examinetic	(Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
completely filled in by the fune Medical Certification	4 Homicide 29e. Certifier 1 C (Check only one)	edical Exam	iner: On the basis	of examinetic		restigation, in my o	opinion, death oc		, date and place,	and due to the cause(s)			
To the Funeral Director: Afte completely filled in by the fundamental Medical Certification	4 Homicide 29e. Certifier (Check only 2 Me) 29b. Signature and title of the control of the con	certifier Dal,	completed cause of	of examinetic	23a) (Type,	29c. Licens	opinion, death oc		, date and place,	and due to the cause(s)			

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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Laura January 27, 2000 Main Martin 7:20 AM 4b. City. Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death Frederick frunder 24 Hrs. 8. Data of Birth (Month, Day, Year) Citizens Nursing Home Frederick If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months 1 M 20 F Yrs. 215-19-3131 89 Sept. 10, 1910 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Maryland Frederick Frederick 10a. Street and Number 10f. Zio Coda 10g. Citizen of What Country? 200 West 12th Street 21701 U.S.A. 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Giva 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stalus Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yas 2 ☑ No Specify: ģ 3 ₩ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George W. Main Margaret Lare 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley R. Martin - Son 23421 Slidell Road, Boyds, Maryland 20b. Placa of Disposition (Name of camatery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Hill Cemetery 1/30/2000 Monrovia, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M 20872-011 Approximate Interval Batween Onset and Death immediata Causa (Final CORONARY ARTERY DISEASE 10 YEARS disease or condition resulting in death) Dua to (or as a consequence of). Sequentially list conditions, if any, leading to immediata cause. Enter Undartying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ⊠Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation

Examiner physician and s the burial-transit that the death certificate be executed P.O. Box 68760. Physician/Medical 65 3 signed b Records. by Completed certificate Division of Vital To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

show

Rerrs 23s or 28e-f show ner must be notified at

natural, or

Hygiene. Oher Dan

Department of Health and Mental Hy important: If them 27 is marked other any Injury or other treuments.

Physician /Medical

Examiner

Directo

Funeral

Be

with the Maryland

filed within 72 hours after

altimore, Maryland 21215-0020

6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homleide

10 'Certifying Phyelcian: To the best of my knowledge, daath occurred at the time, date and placa, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the causa(s) and manner stated. 29a. Cartifier (Check only one)

29b. Signature and title of certifian 29c. License number 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

170 Thomas Johnson Dr., Suite 100, Frederick, Md.

D46075

January 27, 2000

State Registrar

Medicai

Mary P. Howell, M. 1 32. Registral Signatura

many P. Howell mo

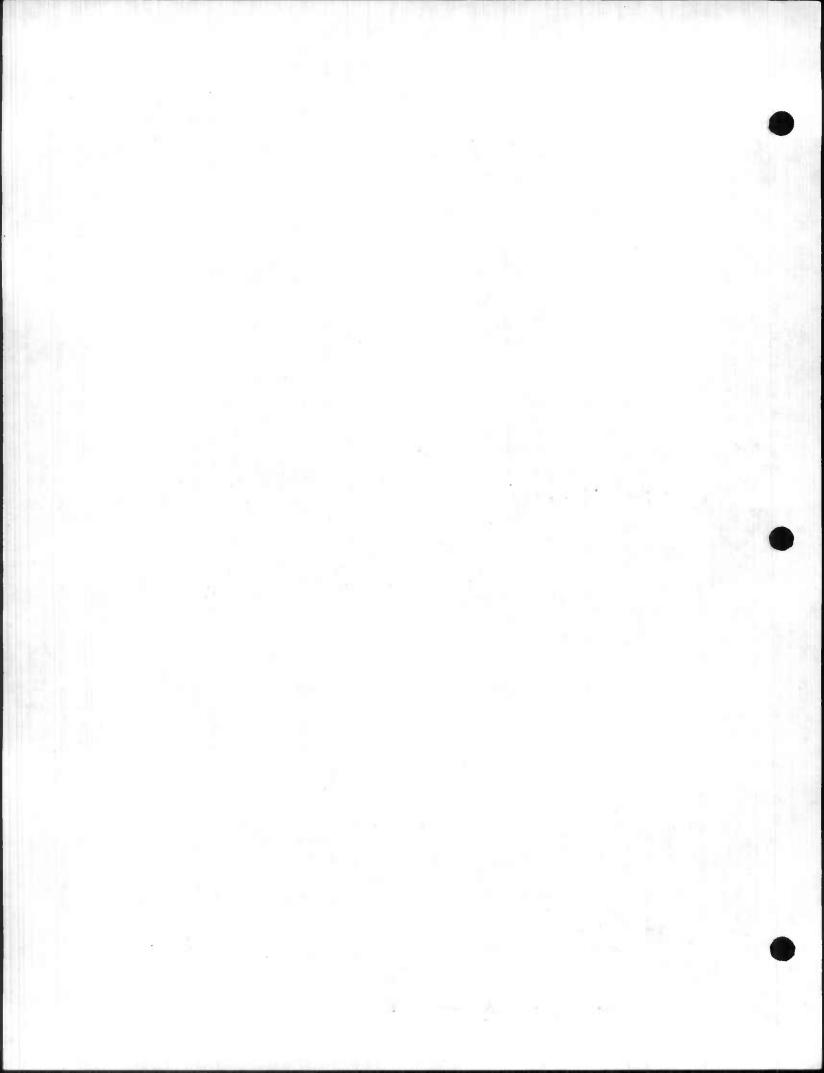
of days and

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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			-	6 0

		U	enilicate of	Dealli	R	leg. No.		
Physician /Medical	1. Decedent's Neme (First, Middle, Last) Glenda Mary Katherine	Moyer			2. Dete of Dea January	7 27 , 20		4:18 PM
Examiner	4e Fecility Neme (If not institution, give street and number) 90 Waverly Drive, Bld. El	E, Apt.	101	4b. City, Town, or Lo		4c. County Frede		
Funeral Director	223-11-3885 ¹□M 2ĀF 3	yrs. last birthda 7 Yrs.	Months Davs		8. Dale of Birth Month, Day March	, 1962	9. Birthplace Country) Washing	ston, DC
Maryland ef show filed at		. city, Town or Frederi						Inside City Limits
O ther death with the Maryla r larms 23s or 28s-1 shot siner must be notified at Furneral Director	10e. Street and Number 90 Waverly Drive, Bld. EE, A	pt. 101	10f. Zip Code 21702		1	10g. Citizen of What Country? U.S.A.		7
_ 9 #8 2	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in Armed Forces? 1 Yes 2 Date If Yes, Give Yeer or Deles:	n U,S. 1	3. Wes Decedent of If Yes, specify Cul	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- Rican, etc.) 14. Race - Ame Black, White Specify: White			
Maryland 21215-0020 d2 should be fied within 72 hours at the and Mental Hygiens. It is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	(Gi	cedent's Usuel Occu ive kind of work done s. DO NOT use retin ISWering S	during most of work ad)	ing	16b. Kind of Bu		
yland 2 void be filed Mental Hygie riked other effic event, it	17. Father's Neme (First, Middle, Last) Harold Jeffrie			18. Mother's Nemo	e (First, Middle, I		eason	
	19a. Informent's Neme/Relationship (Type, Print) Ronald W. Moyer, husband			or., Bld.				
altimore, mit. Pages 1 ar partment of Hea portant: If Hean y injury or othe	1 Rurial 2 Comption 2 Pamoual from State	cemetery, c	sposition (Name of crematory or other place of crematory)	Jan. 28, 20		20c. Location - Smithst		
Ball permit Depart Import any inj anse	21. Signature of Funerel Service Licensee MOO:	255		d Basford Church St				701
Physician /Medical Examiner	resulting in deeth)	umonia		ing, such as cardiac	or respiretory err	rest,	Int	proximete lervel Between nset and Deeth
axecuted in and hel-transit Examiner			Sclerosis				8	Years
ox 68760 certificate be nding physicia use as the burn n/Medical	if eny, leeding to immediate cause. Enler Underlying Cause (Disease or Injury	o (or es a cons						
ha deeth ha deeth the atterched for ched for ysician	Part II. Other eignificant conditions contributing to death but not	resulting in the	e underlying cause g	iven in Part I.	23b. Did to	obacco use cor	ntribute to th	e cause of death
T the year of					101	20(No	3 Probab	ly 4 ☐ Unknow
v requir					24e. Wes a perfor	an autopsy med?	availa	autopsy findings ble prior to lelion of cause ath?
f Vital Reyysician: The lavysician: The lav director, page 2 for Be Comp					1 🗆 Y	es X No	1 🗆 Y	es 2□ No
Of Vita Physician: this certific ral director, To Be	25. Was case referred to medical axaminer?		10	26. Place of Deet				
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ISION Hending death. stor: After / the fune	1 Neturel 5 Pending (Month, Dey Year 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Dey Year) Injury Work? M 1 Yes 2 No		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,			oute Number,	
DIV To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by Medical Certif	29a. Certifier XXCertifying Physician: To the best of my	knowledge, de	elh occurred et the t	ime, date end place,	City or Tow	ause(s) end ma	nner as state	od.
he Hospi in 24 hou he Funer pletsly fill edical	(Check only one) 2 Medical Examiner: On the basis of exemend menner steled.	ninetion and/or	investigation, in my	opinion, deeth occur	ed at the time, d	late and plece,	and due to the	e cause(s)
To the within To the comple	29b. Signeture and MS of certifier		- A-	26660		29d. Dete signed January		
	30. Neme and address of person who completed cause of death (Itam 22a) (T		2000			, _	
	Marc Raphaelson, M.D., 1			on Drive,	#100, F	rederic	k, MD	21702
State Registrar	31. Date filed (Month, Day, Year) AN 3 1 2000 32. Registrer's SI		6. do	resi				



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Ruth Frances Murphy 26, 2000 1:31 PM January 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Frederick Health Care Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Hours 1 M 2 XF Days Months 75 219-14-9052 27, 1924 Maryland Usuel Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Frederick I jamsville 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 10701 Fingerboard Road 21754 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Detes: White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 self homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Otho Francis Duffey Alice Summers 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Casper Charles Murphy, husband 10701 Fingerboard Road, Ijamsville, Maryland 21754 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 2000 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 Donation 5 ☐ Other (Specify) Olivet Cemetery Frederick, Maryland 21. Signeture of Funerel Service Licenses 22. Neme end Address of Fecility Keeney and Basford Funeral Home 23a. Pert1. Enter the disease, or complications that baused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. MO0999 106 East Church Street, Frederick, MD 21701 Approximate Interval Between Onset and Death reast Cancer Immediate Cause (Final diseese or condition resulting in death) eas Can Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequenca of): 23b. Did tobacco use contributs to the cause of death? No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy

Physician /Medical Examiner

and

å.

signed by

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Box 68760,

P.O.

Records.

Division of Vital

Physician

/Medical

10a Stete

Funeral

Director

r 28a-f show .notified.st ahow

"natural", or itsms 23a or the Medical Examiner must be

filed within 72 hours after Hygiene. Wher then "natural", or its

permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Importants if them 27 is marked other the any Injury or other trees.

altimore, Maryland 21215-0020

2

Directo

Funeral

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Completed

Be

2

Physician/Medical by Be Certification:

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Completed 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Tes 2 🗆 No investigetion 2 Accident 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

6 Could not be determined

28d. Describe how injury occurred

28t. Location (Street and Number or Rural Route Number, City or Town, State)

2 No

1 ☐ Yes 2 ☐ No

29e. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29c. License number

29b. Signeture and title of certific

D47556

29d. Date signed (Month, Dey, Year) 00

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

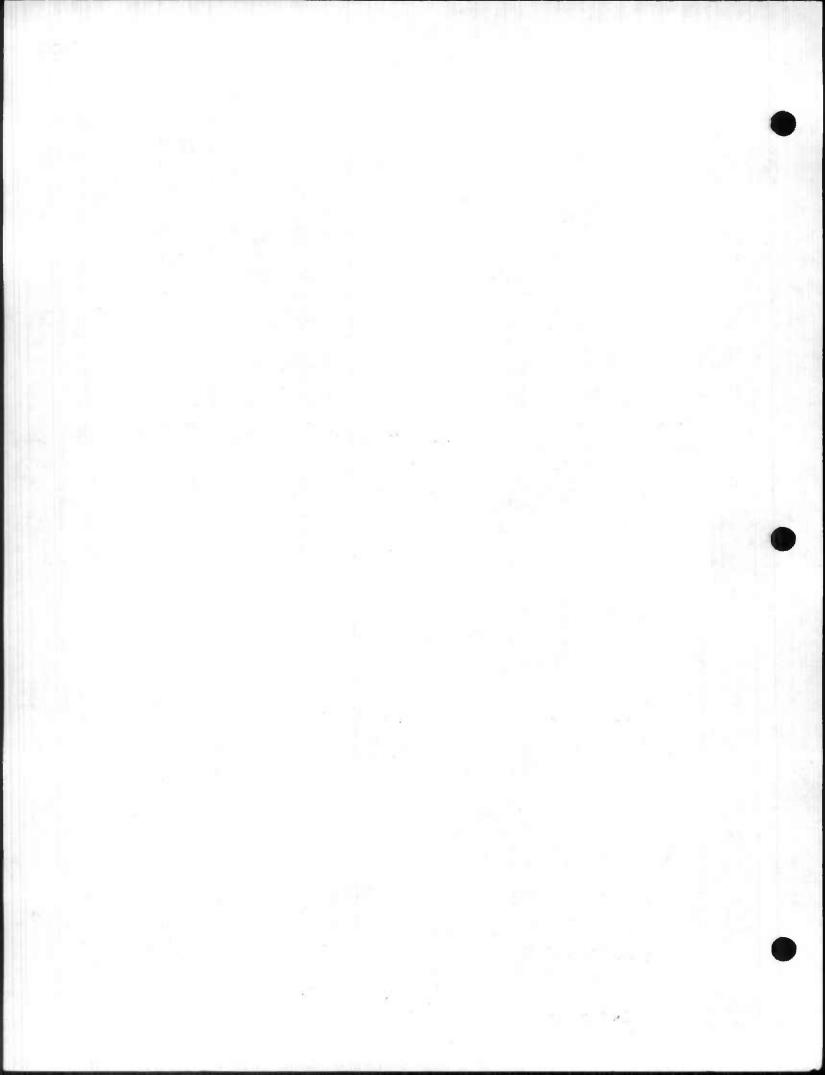
William H. Johnson, 31. Dete filed (Month, Dey, Year)

JAN 2 7 2000

172 Thomas Johnson Drive, Suite 202, Frederick, MD 21702 MD 32 Registrer's Signeture

State Registrar

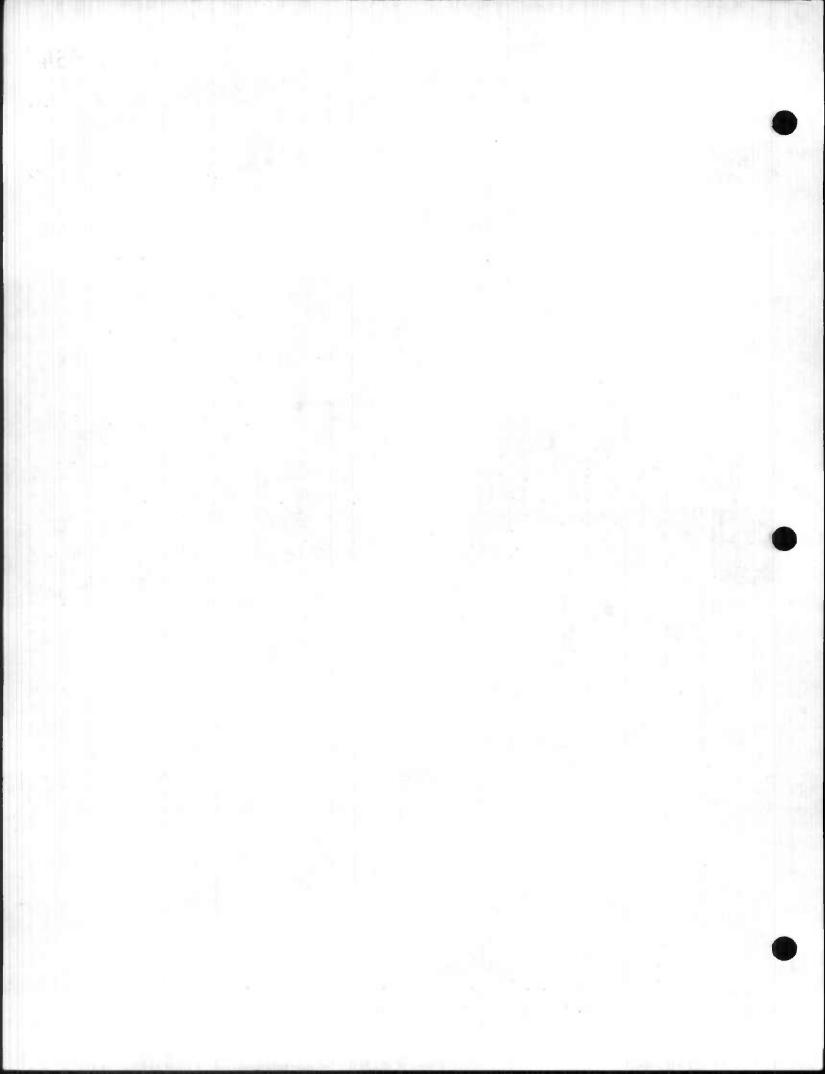
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State of Maryland / Department of Health and Mental Hygiene

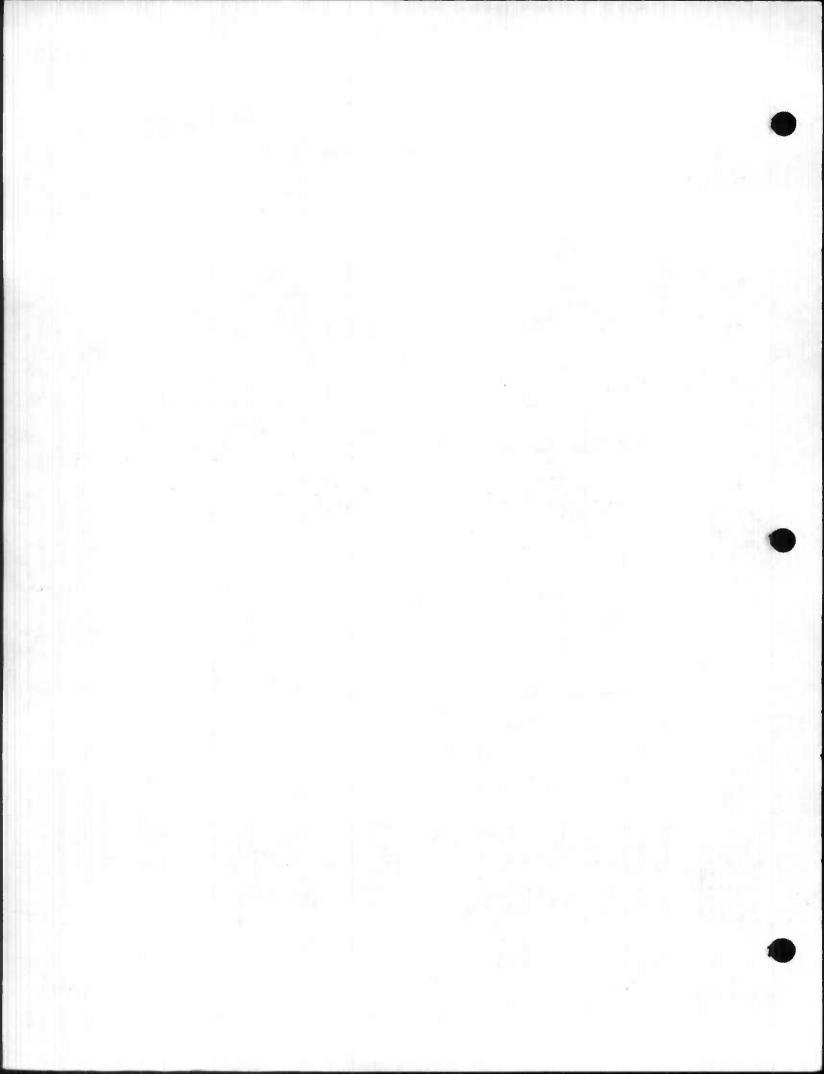
		,,,,	Certificate of Death	Reg. No.	00 04554
	1	Decedent's Nama (First, Middle, Last)		2. Date of Death	3. Tima ot Death
	sician edical	ELIZABETH AMELIA	McCLEAF	JANUARY 23,	2000 1:10 P.M.
100	miner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Lo		ounty of Death
Y		17235 MOUNTAIN VIEW RD.	EMMITSBUR		DERICK
Fune Direct		5. Social Security Number 203-10-7578 Usual Rasidence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs.	Months Days Hours Min.	8. Data of Birth (Month, Day, Year) SEPT.11,1902	9. Birthplace (Stata or Foraign Country) FAIRFIELD, PA.
Vand Mand			ity, Town or Location		10d. Inside City Limits
Man	to	MARYLAND FREDERICK EN	MMITSBURG		1 ☐ Yas 2 No
or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizer	n of What Country?
death with the Maryland	le	17235 MOUNTAIN VIEW RD.	21727	U.	S. A.
5 2 2	Funeral	11. Maritat Status 12. Was Decedent Ever in U Armed Forces?	J,S. 13. Was Decedent of Hispanic Origin? (Spe If Yas, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Race - American Indian, Black, Whita, atc.
21215-0020 d within 72 hours after piene. r than "natural", or te	by	1 Never Married 2 Married 1 Yes 2 No If Yas, Giva Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		pecify: WHITE
72 r	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Giva kind of work done during most of workii life. DO NOT use retired)	na	of Business/Industry
within within	d L	Elementary/Secondary (0-12) College (1-4or 5+)	DIETARY DEPT.		IOSEPH'S LEGE
	Ö	17. Father's Nama (First, Middle, Last)		(First, Middle, Meiden Su	
Maryiand d2 should be file th end Mental Hy 71e marked oth traumatic event	To Be	JACOB PETER EIKER	C	ARRIE HERRIN	G
should benta marked	-	19a. tnformant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Flura		
CENL		ALBERT WAYNE McCLEAF/SON	17335 MOUNTAIN VIEW RD	., EMMITSBUR	G, MD. 21727
St Te		20a. Method of Disposition 20b. I	Place of Disposition (Nama of cematary, cremetory or other place)	1	tion - City or Town, Stata
Pages nent of mrt: If h		1 Labural 2 Li Gremation 3 Li Hemoval from Stata		7/2000 EMMI	TSBURG, MD. 21727
Baltimore, pemil. Pages 1 e Department of Hee Important: If flam any injury or othe	POCE	21. Signature of Funeral Service Licensee		KILES FUNERA	
		23a. Pans. Enter the disease, or complications that caused tha deat	210 W. MAIN ST., EN		D. Z1/Z/
Physicia /Medic Examina	al er	tmmediete Cause (Finel disease or condition rasulting in death) Due to (c	or as a consequence of):	zonotth	Onset and Death
betwar b	Į,	Sequentially list conditions	or as a consequence of):		1 -0.90
an en rielt	EX	if any, leading to immediata cause. Enter Underlying			V
bor bou, ifficate be executed g physician end as the buriel-transit	edical Examiner	Cause (Disease or injury	or as a consequence of):	-	
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the de	Phyaician/N	Part It. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part t.	23b. Did tobacco us	a contributa to the causa of death?
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requires to seen signe hould be	d by			24a. Was an autopsy	24b. Were autopsy tindings
v require been si should	lete			performed?	available prior to completion of causa
The law require at a has been si page 2 should I	Completed			V.	of death?
VITAL sicien: Tr certificate irector, pa	Ö	25. Was case refarred to medical	00 81101	1' Yas 2	No 1 Yas 2 No
Of VICE Physician: rithis certific ral director,	To Be	axaminer?	26. Place of Death 2Fr/Outpatient 3 DOA Other: 4 Nursing Hor	ma 5X Residence 6	Other (Speciful
or Attending Phyrater deeth. Director: After this Jin by the funeral di	Certification: T	27. Manner of Death 1 ⊠ Natural 5 □ Pending 28a. Data of Injury (Month, Day Year)		28d. Describe how injury of	
deet ctor:	flea.	3 Suicide 6 Could not be 28e. Place of triury - At h		28f. Location (Street and I	Number or Rural Routa Number,
die de la	T.	4 Homicide building, etc. (Specif	(y)	City or Town, Steta)	
To the Hospital or Attanding Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edicai C		owledge, death occurred at the time, date and place, a atton and/or investigation, in my opinion, death occurred		
To the within 2 To the	M	29b. Signature and title of country	29c. License number	29d. Date :	signed (Month, Day, Year)
FSFS		D (NVa (ON 11 A	LIMW DIEDAT		
		30. Nama and address of person who completed cause of death (Item	m 23a) (Type, Print)	24	JANUARY 2000
		ALAN CARROLL, M.D. 310 S. SE		. 21727	
	State	31. Data filed (Month, Day, Year) 32. Registral's Signa		y to ser to f	
Regi	strar	JAN 2 7 2000 Dane	d. Sparks		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 04555

	State of Marylan	Certific	cate of Deat	h	Reg. No.	04000			
)				leath Day	3. Time of Death			
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An Planting Manage 194 and forest atom at in-	street and number)		4b. City,	Town, or Location of Dea					
200 Fair	iew Avenue		Fr	ederick	Free	derick			
214-28-0188	THE OF S	Mo		Min. (Month, L	orth Pay, Year)	9. Birthplaca (State or Foreign Country) Maryland			
10s. State 10b. County	10c. City	y, Town or Location	n			10d. Inside City Limits			
Maryland Freder	ick F	rederick				1⊠ Yes 2□No			
10e. Street and Number 200 Fairview Avenu	ie	10		1		•			
3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 N Yes 2 No 194	+3- 10 Y			Black	- American Indian, , White, etc. White			
15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give kind o	of work done during me OT use retired)	ost of working					
17 Esthare Name (Circl Middle Leet)	2	Enginee		har's Nama (First Middle					
E41	fillor N	fontz							
			the state of the s						
						ick, Maryland			
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home									
23a. Part1. Enter the disease, or complishock, or heart feilure. List only or	cations that caused the death re cause on each line.	n. Do not enter the	mode of dying, such a	s cardiac or raspiratory	arrast,	Approximate Interval Between Onset and Death			
Immediate Cause (Finat disease or condition resulting in death)						10 years			
	Due to (or	r es a consequenc	e of):	lar Disease		20 years			
Don't Other significant and dilega and	stribution to doubt but not not	daine in the condect.	ring agrees about in Day	41 206 01	d tobassa use sool	hilbridge to the annual of death 2			
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	aurc Heer Orce	rs;							
				24a. Wa	is an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?			
	Insufficiency;			24a. We per		available prior to completion of cause			
Chronic Renal I Right Hip Fract 25. Was case referred to medical examiner?	Insufficiency;			24a. We per	ormed? Yes 22 No	available prior to completion of cause of death?			
Chronic Renal I Right Hip Fract 25. Was case referred to medical examiner? 1 🖾 Yes 2 🗆 No	Insufficiency;		DOA Other: 4	24a. We per 1 Cocc of Death (Check only Nursing Home 53 Re	Yes 22 No	available prior to completion of cause of death? 1 Yes 2 No			
Chronic Renal I Right Hip Fract 25. Was case referred to medical examiner? 1 🖾 Yes 2 🗆 No	Insufficiency; cure lospital: 1 Inpatient 2	ER/Outpatient 3(28b. Time of Injury	DOA Other: 4 28c. Injury at Work?	24a. We per 1 Coc of Death (Check only Nursing Home 532) Re 28d. Describ	Yes 22 No Yone) sidence 6 Othe	available prior to completion of cause of death? 1 Yes 2 No			
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	Edward. 4a Facility Name (If not institution, give: 200 Fairv. 5. Social Security Number	4a Facility Name (If not institution, give street and number) 200 Fairview Avenue 5. Social Security Number 214-28-0188 Usual Residence of Decedent 10a. State 10b. County 10c. City Maryland Frederick 11. Marital Status 12. Was Decedent Ever in U. Armed Forces? 13. Was 2 No 192. If Yes, Give Year or Dates: 192. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 17. Father's Name (First, Middle, Last) Edward Miller 19a. Informant'a Name/Relationship (Type, Print) The Lma Crum Mantz/ Spouse 20a. Method of Disposition 11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 11. Marital Status 12. Was Decedent Ever in U. Armed Forces? 13. Was Decedent Ever in U. Armed Forces? 14. Yes, Give Year or Dates: 192. In the Status of the College (1-4or 5+) 2. The Lma Crum Mantz/ Spouse 20a. Method of Disposition 11. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 14. Donation 5 Other (Specify) 22. Part I. Enter the disease, or complications that caused the death shock, or heart feiture. List only one cause on each line. 15. Due to (or Arteriosc) 16. Arteriosc 17. Due to (or Arteriosc) 18. Due to (or Arteriosc) 19. Due to (or Arteriosc)	1. Decedent's Name (First, Middle, Last) Edward Haugh	The Decedent's Name (First, Middle, Last) Edward Haugh Mantz	Edward Haugh Mantz Januar Month Month Month Month As Facility Name (if not institution, give street and number) 200 Fairview Avenue 5. Social Security Number 214-28-0188 101 M 2D F 88 Yrs. 102 M 2D F 88 Yrs. 103 M 2D F 88 Yrs. 104 Month Day's Hours Win. 105 City, Town or Location Prederick 106. Street and Number 108. Street and Number 109. Street and Number Frederick 100. Street and Number Congin? (Specify Yes or Number forces) 109. Street and Number Congin? (Specify Yes or Number forces) 109. Street and Number Congin? (Specify Yes or Number forces) 109. Street and Number Congin? (Specify Yes or Number forces) 109. Street and Number Congin? (Specify Yes or Number forces) 109. Street and Number Congin? (Specify Yes or Number forces) 109. Street and Number Congin? (Specify Yes or Number forces) 109. Street and Number or Rural Route Num 109. Informart's NumerFielelstonship (Type, Print) 109. Print (Type, Print) 109. Print (Type, Print) 109. Print (Type, Prin	1. Decodent's Name (First, Middle, Last) 1. Decodent's Name (First, Middle, Last) 2. Description of Decoders (Prederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Social Security Number 6. Sex 12M 2 F 7. Age (fir yrs. last birtholay) 1. EUnder 1 Year FUnder 24 Hrs. 8. Quas of Burth Day Hours Min. 1. Months Day			

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 04556 Certificate of Death Amended item#26per doctor !/27/00 1. Decedent's Name (First, Middle, Last) FCHD KS Pate of Death 3. Time of Death Month

Funeral	
Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 Is marked other than "natural", or hems 23s or 28s4 show

Baltimore, Maryland 21215-0020

Physic /Med Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

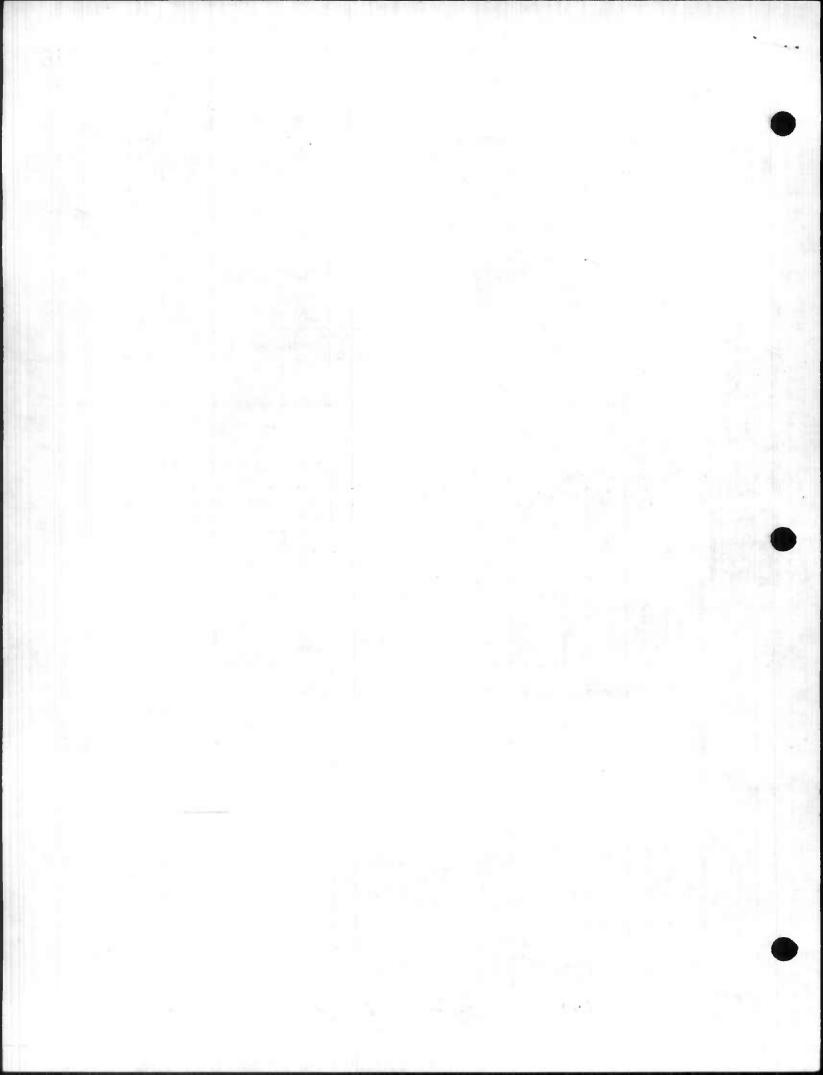
To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760.

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5. Social Security Number	6. Sex	- 1	. Age (In yrs.	last birthday) If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. Birthpla	ace (Stele or Fore
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Owen		Ahern					Elean	nor		Caulfi	614	
9e. Informent's Neme/Releti	onship /Tvr			19b. Meil	ina Address	(Street			al Route Numb	er, City or Town,		Code)
Bob Masser / Oa. Method of Disposition	son		20b F	Plece of Disp			Leet,	rior	gan, Ne	W Jersey		
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21. Signature of Funeral Serv	CONTRACTO	0 1	/ /	// 2	2. Name en	d Addres	ss of Fecilit	tv				
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23a. Per 1. Enter the disease	or complic	aticks that ch	ac f							ont, Mai		1_21/88 Approximete
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esulting in deeth) Lest			Due to (o	r es e conse	quence or):							
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7. Manner of Death 1 ☐Natural 5 ☐ Per	adina	28a. Dete of (Month)	Injury Dey Year)	28b. Tima o	y 2	Bc. Injun Wor	y at k?		28d. Describe	how injury occur	red	
2 Accident inv	estigetion				М		Yes 2□	No				
dot	uid not be ermined	28e. Plece o	f Injury - At he	ome, ferm, s	reet, fectory	, office				Street and Numb	er or Aural	Route Number,
4 Homicide		building	g, etc. (Specif	y)					City or To	WII, SIBTE)		
29e. Certifier 17 Certi	fvina Phyel	clan: To the h	est of mu ken	wlados desi	h occurred	at the ti-	ne deto ==	d place	end due to the	cause(s) and me	nner ee ee	ted
	cal Examin	er: On the bas	is of examine	tion and/or in	vestigation,	in my o	pinion, dee	th occurr	ed at the time,	date end place,	and due to	the cause(s)
9b. Signeture end title of cer	ifier	end menne	, 31E(8U.		20-	Lienne	e number			20d Data dian-	d (Manth P	ley Veerl
So. Signatura and title of cer	(IIII)	0		_	290	. LICHTS	9 HUMBOR			29d. Dete signe	u (wonth, D	wy, rear/
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00. Name and address of pers	on who con	npleted cause	of deeth (Item	23a) (Type						1	1	
HARPER, WILL			South			et	Thurs	nont	MD 2	1788		
THE CALL OF THE PARTY	TULL L	. 100	JULIER	CHICE	DELE		THUT	monte,	1111/2	1/00		

DHMH 16 Rev 6/95

State Registrar 7 2000 Signatura Signatur



Maryland / Department of Health and Me	ntal Hygiene UU	0455
Certificate of Death		-

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 20, 2000 **Physician** MARIA MARTINELLI 1:50 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMEORIAL HOSPITAL FREDERICK FREDERICK Hours Min. NOV 12, 3 ear 941 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕅 F 58 (None) Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28s-f show ¥ Yes 2 No Funeral Director MD. FREDERICK FREDERICK traumatic event, the Medical Examiner must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or? 1181 SCHAFFER DRIVE 21702 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) then. Elementary/Secondary (0-12) 10 TH College (1-4or 5+) HOUSEWIFE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARIO MARTINELLI LUSITANIA DEL DOTTO To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stets Tip Coop) 19a. Informant's Name/Reletionship (Type, Print) DELLI (SON) MAX 1181 SCHAFFER DRIVE FREDERICK, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY JAN. 21,2000 BALT. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME a. 110 WEST SOUTH ST FRED. MD. 23a. Part1. Enter the diseese, or comp shock, or hear tailure. List only cations that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, the cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pu Due to (or as a consequenca of) Upper Blac 6 Box 68760. physician Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been signed by funeral director, page 2 should be detac Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manper of Death 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick

State Registrar S.

JAN 2 1 2000

a.mes

31. Date filed (Month, Dey, Year)

Grisson

DHMH 16 Rev 6/95

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Mil

32. Pegistrar's Signature

St.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #19b, 2/3/2000, BMW, Montq. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Dev **Physician** Catharine Elizabeth Nolan 25, 2000 January 10:40pm /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | Months Deys tf Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Hours 1□M 2⊠F Yrs 89 Director 579-42-1491 5, 1910 Pennsylvania Usual Residence of Decedent the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23s or 28s-f show the Madical Examinar must be notified at 1 Yes 2X No Director Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9705 Old Georgetown Road #2220 20814 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Raca - American Indien, Bleck. White, etc. 72 hours after ☐ Yes 2 No f Yes, Give 1K Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 28 No Specify Specity: à 3 Widowed 4 Divorced Yeer or Detes White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Georgetown Visitation Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) School. 4 Alumni Secretary Department of Health and Mental Hygis important; if Hem 27 is marked other any Injury or other trauments 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be James Bennett Nolan Emily May Smink 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) RR1. Sedgwlck 19a. Informant's Neme/Reletionship (Type, Print) RR Box 180, Jane Heizmann (Cousin) Sedwick Maine 04676 20a. Method of Disposition 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) |2/2/00 | Alexandria, Virginia | DeVol Funeral Home | Yenue, N.W. Metropolitan Crematory 22. Name and Address of Facility DeVol 2222 Wisconsin Avenue, 21, Signature of Funeral Service Licensee Washington, DC 20007 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one cause on such line. Approximete fntarvel Between Onset end Deeth **Physician** PNEUMONIA /Medical immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner FAGURE Hip certificate be executed and Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) attending physician for use as the buria Box 68760. Physician/Medical Due to (or es e consequence of): P.O. P Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? signed by 1 Yea 2 No 3 Probably 4 Unknown TRACTURE HUMERUS Records, à 24b. Wera autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 2 0 No 1 Yes 2 No certificata Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completaly filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. fnjury at Work? 28a. Dete of tnjury (Month, Dev Year) 5 Pending investigation 1 Netural SLIPPED ON FLOOR OF HOME DECOMBR 97, 1999 1900 1 ☐ Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifine

12 8

State

Registrar

29b. Sig

shine

29c. License number

29d. Dete signed (Month, Dey, Year) FEBRUARY 2, 2000

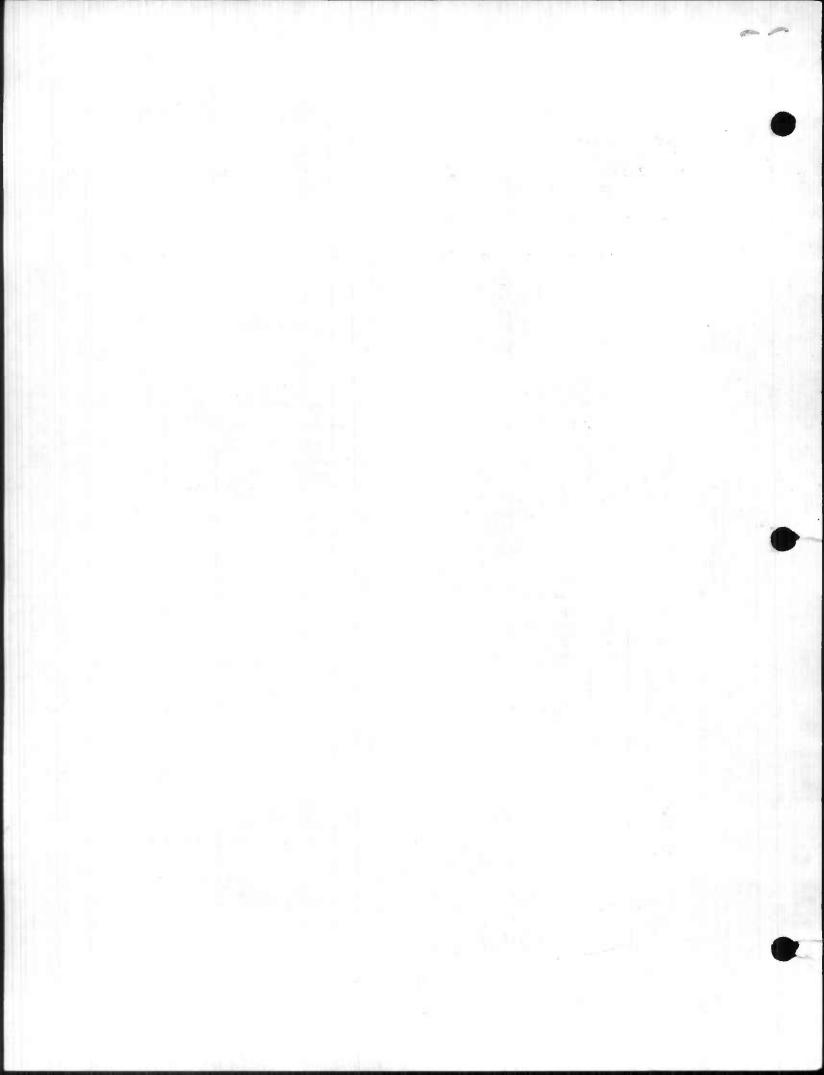
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11/25 AOCKVILLE PIKE, PECKVILLE, MOZOBER

31. Date filed (Month, Dey, Year) FEB 03 2000

and title of certifier

32. Pegistrer's Signeture



State Registrar 31. Date filed (Month, Day, Year)

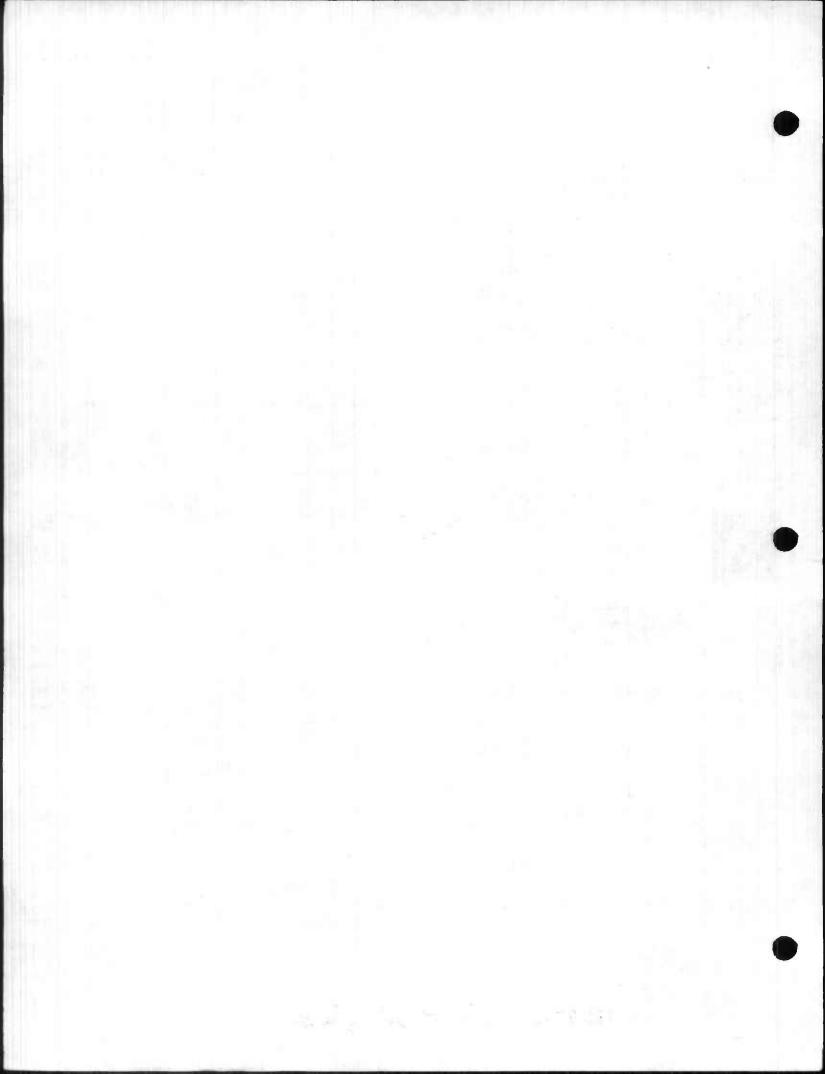
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Separation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Soul

111 Penn Street, Baltimore, Maryland 21201

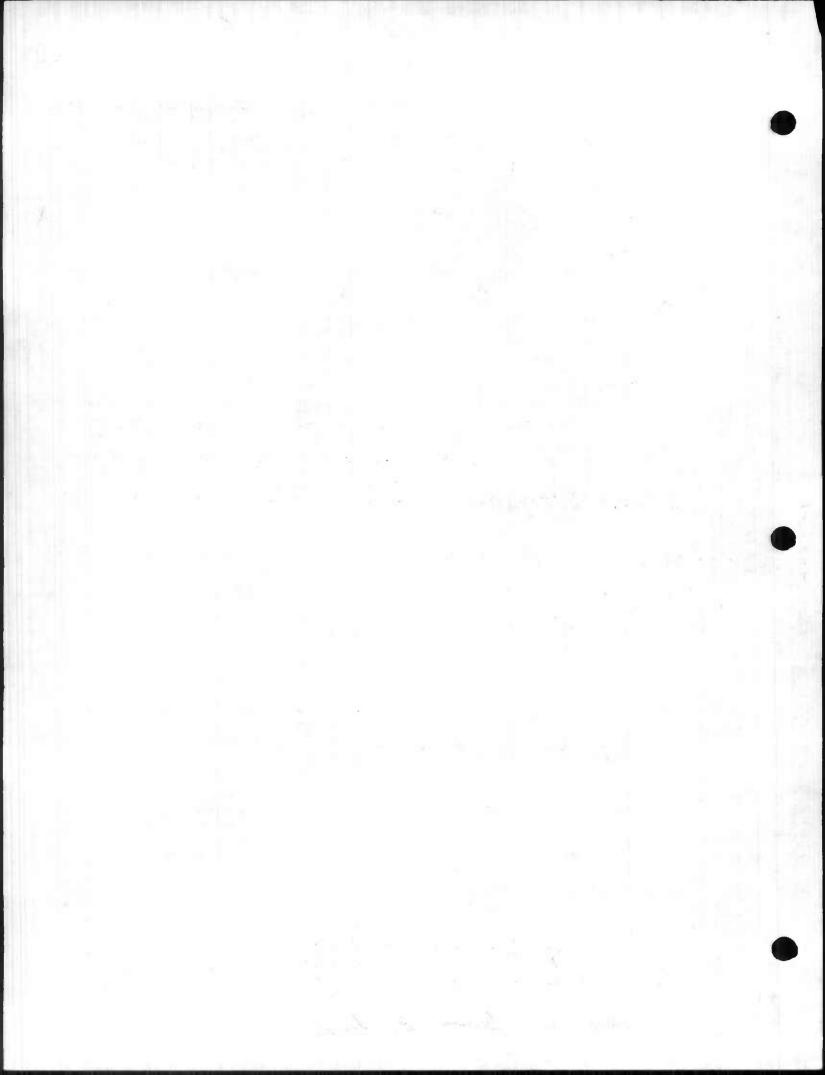


State of Maryland / Department of Health and Mental Hygiene

04560 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer Month **Physician** 1900 Nelson 4b. City, Town, or Location of Death 28 Frances 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 11/28/1906 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Maryland Director 213-74-4267 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Westover Somerset Maryland Director 238-1 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? ŏ 21871 USA 238 9957 Weldon Nelson Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: à ₩Widowed 4 Divorced White Yaar or Datas: Completed t6a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) 89 Pages 1 and 2 should be nent of Health and Mental is marked Mary Ellen Rowe Frank M. Widdowson 19a, Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: if item 27 is any injury or other trau 4632 Nutters Cross Road, Salisbury, Md. 21804. Peggy Maloney/Daughter 20a. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Buriei 2 Cramation 3 Removal from Stata Manokin Presbyterian Cem. 02/01/2000 Princess Anne, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Facility
Hinman Funeral Home Signeture of Funeral Service Licensee 11673 Somerset Ave., Princess Anne, MD. 21853 SUKKALM00295 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Deeth **Physician** Apterioscleratic Heart Risease Immediate Cause (Finet disease or condition rasulting In death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Disease or Injury that initieted events rasulting in death) Last Due to (or es e consequence of): 68760 Physician/Medical the Due to (or as a consequence of) The law requires that the death Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown signed be de Records, þ 24b. Wera sutopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No this certificate Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1_Inpatient 2 ER/Outpatient 3 DOA 27. Mennes of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Neturai Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homleide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier the state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 rangelista 31. Data filed (Month, Day, Year) 32. Registrer's Signetura State Registrar

DHMH 16 Rev 6/95

ORIGINAL



00-0598-027 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 1 PER G78 tate of Maryland Department of Health and Mental Hygiene 0 0 AMEND ITEMS: #23 PART I, II, 27, 28Acterificate of Stan 2-15-2000 WR. DENISE OLIVER 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Denise M. Olivier FEBRUARY 1,2000 1:01P.M. /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8640 TOWN & COUNTRY BLVD HOWARD ELLICOTI If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs. 218-76-8530 33 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limite Ellicott 1 Yes 2 No MD Howard 28a-fa Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 8640 Town & Country Blvd 21043 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🖾 No If Yes, Give 1 ☑ Never Merried 2 ☐ Merried 8 Maryland 21215-0020 1 Yes 2√ No Specify: White by Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MHA Quality Elementery/Secondery (0-12) College (1-4or 5+) Indicator Project Accountant 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Ruth Ann Gellner Olivier George J. Olivier Jr. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) Hem 27 i Westminster, MD 21157 903 Magnolia Ct. Ruth Olivier/Mother Baltimore, 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of I ò 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 2/5 Meadow Branch Westminster, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fundral Service License 22. Name end Address of Facility Pritts Funeral Home and Chapel 23a. Pert1. Enter the scales, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in the List only one cause on each line. MD 21157 Approximate Intervel Between Onset and Death Physician NARCOTIC INTOXICATION /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Physician/Medical that initieted events resulting In deeth) Last Due to (or as a consequence of) use as the Box (P.O. | 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. COCALINE USE 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown of Vital Records, þ page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☑Yes 2 □ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No Certification: To this 28a. Dete of Injury FOUND Dey Year) 2-1-2000 28c. Injury et Work? 27. Manner of Death 28b. Time of P 28d. Describe how injury occurred Affer Division FOUND: 12:45 1 Neturat 5 Pending investigation after death. 1 ☐ Yes 2 No UNKNOWN 2 Accident the 3 Suicide 6X Could not be determined 281. Location (Street and Number of Russ Route Number UNITY City or Town, State) 8640 TOWN & COUNTY BLVD., ELLICOTT CITY, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND AT HOME filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. edical 29a. Certifier 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State Registrar

FEB 0 7 2000

s of person who complete

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31. Dete filed (Month, Day, Year)

32. Registrar's Signature

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ed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 ports

O.C.M.E.

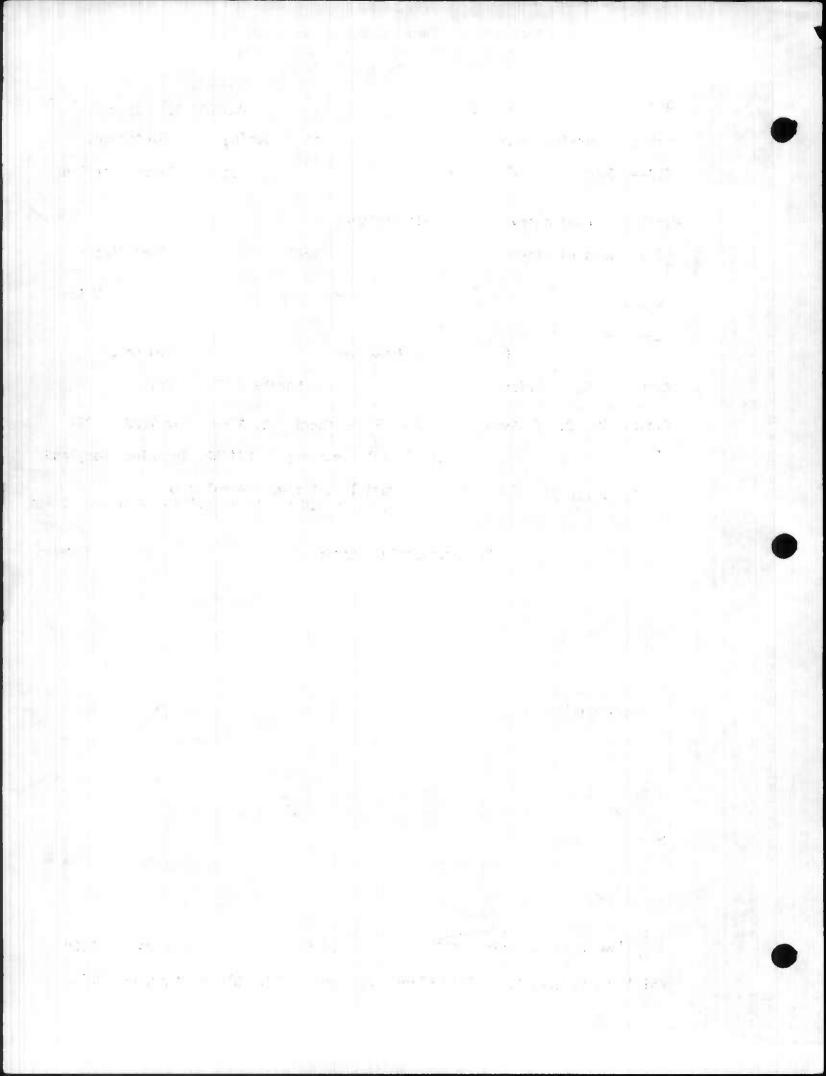
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FERST 2008 Burn S. January

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State of Maryland / Department of Health and Mental Hygiene 0 0 0 4 5 6 2

						Cer	tificate o	f Death		Reg. No.			
			1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	eath Dev	Yeer	3. Time of Death	
	Physicia /Medic		ANNA MARY	OWINGS					JANUAR	,	000	12:05 PM	
1-	Examine		4a Facility Name (If not institution, giv	e street and number)				4b. City, Town, or		th 4c. County	of Death		
			Friends Nursing	Home				Sandy Sp	ring	Mont	gomen	ry	
	Funeral Director		213-40-0400	ex	(In yrs. la.	st birthday) Yrs.	If Under 1 Year Months Day		8. Date of Bir Month, Da Jan	29 1909	9. Birthp Gour Ma 1	place <i>(State or Foreign</i> ntry) ryland	
	2 2	- 1-	Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Loc	eation					10d. Inside City Limits	
	aho at a	-										1 ☐ Yes 2 No	
	B B B	Director	Maryland Montgo	mery	\G	ither	1			40-09	10-10-1		
9	after doorn with the Maryland or items 23e or 26e-f show triner must be notified at	rai Dir	5 900 Dama scus	Road				20882		10g. Citizen of V United	Sta	tes	
Maryland 21215-0020	urs after al', or its Examine	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N if Yes, Give Year or Dates:	101.00	13. Wes Decedent of Hispanic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:				Specify	ck, While,	can Indian, etc. White	
5-6	natural", dical Ex	Completed	15. Decedent's Ed (Specify only highest gra	fucation de completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Bus		usiness/în	dustry	
2	E	ğ.	Elementary/Secondary (0-12)	Coilege (1-4or 5-	+)			ired)				200	
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P.	日本なる	Be	17. Father's Name (First, Middle, Last)										
yla	Me ship	0	August W.	Priebe				Martha	Т.	Brown	1		
ar	Sandra 20a. Method of I Burial 4 Donatio	19e. Informent's Neme/Reletionship (Type, Print)		19b. Mailin	g Address (Stre	et and Number or Re	ural Route Numb	ber, City or Town,	State, Zip	Code)		
		Sandra P. Day	/ Niece				Court, Mt.	Airy,	Marylar		1771		
Baltimore,		20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)		20b. Pla	ce of Dispos netery, crem Cari	sition (Name of patory or other p Ne1 Cen		2/4/00	Sunshir		own, State aryland		
Balt	Departition Departition of the post of the		21. Signature of Funeral Servica Licer	1 10-0	her	NA.	2 . 7 . 11	dress of Facility Barber F	uneral	Home		nd 20882	
	Physician /Medical Examiner	_	23a. Pert1. Enter the disease, or comshock, or heart fellure. List only Immediate Cause (Finel disease or condition resulting in death)	a. Cere	ebrova		r Acci		c or respiratory a	arrest,		Approximate Interval Between Onset and Deeth 3 Weeks	
Box 68760,	physicials the burns of the burns.	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c		as e consequals a consequ							
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P.0	that the de ad by the deteched	h	Hypertension						1	Yes 2 No	3 Pro	obably 4 Unknow	
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Œ	The faw ate hes b page 2 s	Completed							10	IYes 200 No	of	death?	
	ysician: The is certificate he director, page	Be	25. Was case referred to medical					26. Place of De	eth (Check only	one)			
>	Physician: this certific ral director,	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2DE	R/Outpatien	3□ DOA	Other: ANursing I	lome 5 ☐ Res	idenca 6 🗆 Otl	har (Speci	ify)	
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Division	after de Blrecto d in by th	Certification:	3 Sulcide 6 Could not b determined	28e. Pleca of Inju building, etc	ry - At hom . (Specify)	ne, ferm, stre	et, factory, office	СӨ		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	Andreas	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner at the time, determined at the time, determined at the time, determined at the time, determined and manner stated.											
(1	o dithin	Me	29b. Signature end little of cartifier				29c. Lice	ense number		29d. Date signe	ed (Month)	, Day, Year)	
)	10		1. Kenju	12	<u> </u>			35045		January	30,	2000	
			30. Name and address of person who Philip G. Henju					rt, #204,	Olney.	, Maryla	nd 2	20832	
	Stat Registra		31. Date filed (Month, Day, Year) FEB 03 20	32. Registra	r's Signatu	G.	Spar	h					



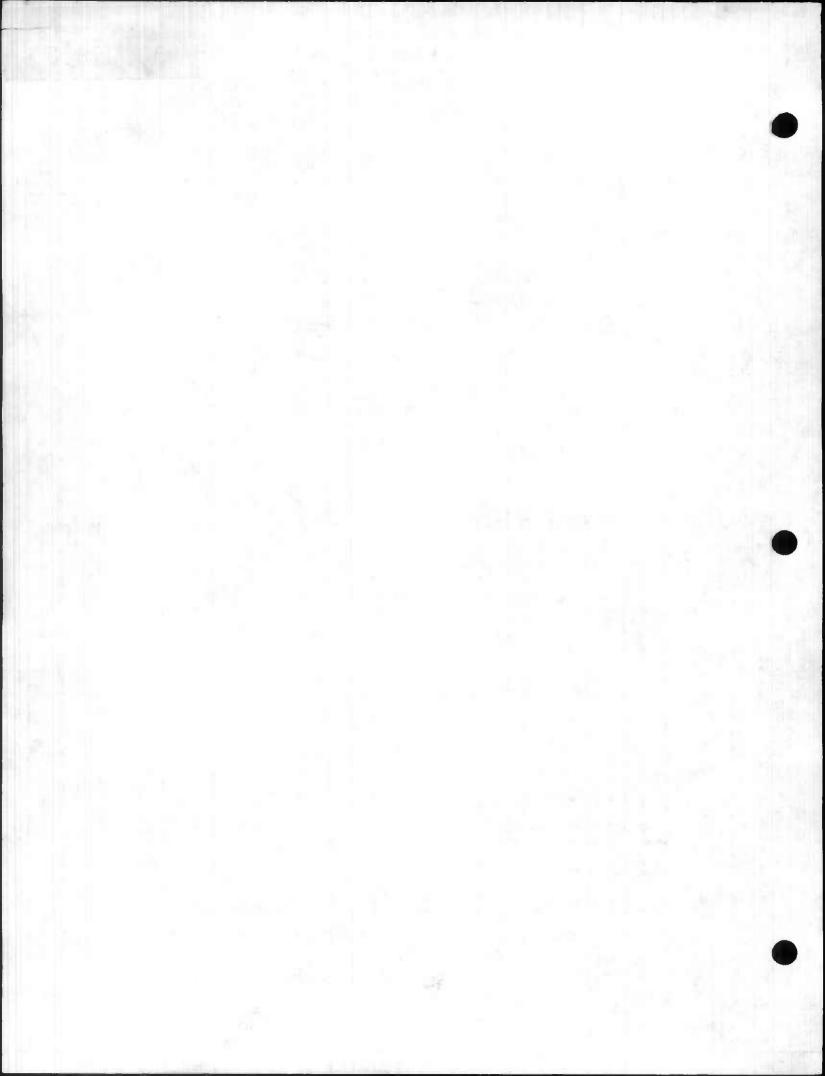
YINKA G. OLOPADE

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State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death		Reg. No.					
	1. Decedent's Name (First, Middle, La	st)			-	2. Date of De Month		Year	3. Time of Death			
Physician /Medical	Grace Olayin	nka Olopad	e			JANUA		000	1745 PM			
Examiner	4a Facility Name (If not Institution, giv DOCTORS COMMUNIT	re street and number) TY HOSPITAL			4b. City, Town, LANHAM	or Location of Deat	h 4c. County of PRINCE		RGES			
* Funeral Director	038-56-4513	Sex 7. Age (In yrs. 30	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Ain. (Month, De	th ey, Year) 20, 1969	9. Birthpl Coun Nige	lace (Stete or Foreign try) ria			
2 2	Usual Residence of Decedent 10a. Stata 10b. County	100 0	ty, Town or Le	ocation				14	0d. tnside City Limits			
Se-f sho			w Carr	ollton					1 No Yes 2 No			
or 2	10e. Street and Number			10f. Zip Code			10g. Citizen of W	het Coun	try?			
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id Z 1 Z 1 Z 1 Z 1 Z 1 Z 1 Z 2 Z 2 Z 2 Z 2	11. Marital Status 1 \overline{\text{M}} Never Married 2 \overline{\text{Married}} Married 3 \overline{\text{W}} Widowed 4 \overline{\text{D}} Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Pu Specify:	(Specify Yes or No Juerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: black					
bour b	15. Decedent's Ed	Year or Dates:	16a Doce	dent's Usual Occup	etion		16b. Kind of Business/Industry					
Maryland ZIZIS-UUZU d 2 should be filed within 72 hours aft th end Mariel hygiene. 7? Is marked other than "natural", or traumatic event, the Mariel Earth To Be Completed by F	(Specify only highest gra	ide completed)	(Give	kind of work done DO NOT use retired	during most of	working	16b. Kind of Business/Industry					
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2 should 2 should end Men la marke aumatic	19a. Informent's Name/Ralationship (ing Addrass (Street								
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mit. Peges 1 ar partment of Hee portant: if hem 2 y injury or othe	20a. Method of Disposition	20b.	Place of Disp	osition (Neme of		Date	20c. Location - 0					
permit. Peges 1 and 2 should be filed within Department of Heelih and Mentel Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Medica. To Be Compl	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery, cremetory or other place) Gate of Heaven Cemetery 2/1/2000 Silver Spring, Mar											
Departm Departm Importar any Injur	22 Name and Address of Facility Rapp Funeral & Cremation Services, Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, Marylnad 20910											
est certificate be executed attending physician and ifor use as the buriel-transit claryMedical Examiner	Immediate Causa (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last	c		OP('e TV quenca of):	ysal p	DEYMAN	ly .					
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. 0 00	Part II. Other significant conditions of	contributing to death but not re-	sulting in the u	underlying cause giv	ven in Part I.	23b. Did	23b. Did tobacco use contribute to the cause of death					
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vicien: Tiector, periodicate of Be Co	25. Was case raferred to medical				26. Place of	Death (Check only	ona)					
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To the Hospital or Attending Physicien: The law within 24 bours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	Wo	ryat rk? Yes 2∐No	28d. Describe	how injury occurr	ed				
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To the Hospital or Attending is the Hospital or Attending in the firm of how to the Funeral Director: After completely filled in by the funeral Medical Certification		ysician: To the best of my kni niner: On the basis of examinated.										
/	29b. Signature and title of certifiar	rethree a	h	29c. Licens O • C		29d. Date signed (Month, Day, Year) JANUARY 28, 2000						
5	30.Name and address of person who	completed causa of death (Ita	m 23a) (Type Penn	Street, E	Baltimo	re, Maryl	and 2120	1				
State Registrar	31. Date filed (Month, Day, Year) FEB 1 2	32. Registrar's Sign		Soone	1							

Registrar



State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month **Physician** MARY MARGARET O'DONOVAN February 2000 4:59 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Clinton Prince George's Southern Maryland Hospital Center If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Steta or Foreign Country) **Funeral** Days Min. 1 M 3 F Months Hours 577-18-5613 Director 1913 West Virginia Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow flores 23a or 28a-f ahov 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3358 Huntley Square Drive Apt. T-2 20748 death Funeral USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give X Yeer or Detes: 1 Never Married 2 Merried 21215-0020 6 1 ☐ Yes 2 X No Specify: White þ Specify: 3 ☐ Widowed 4 € Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Health Care Beautician other treumstic avent, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Pages 1 and 2 should be finent of Health and Mental I int: If frem 27 is marked of Edward Christ Unknown 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Brenda Dugan (Friend) 11238 284 Lafayette Ave Brooklyn, New York other Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State = 8 1 Buriel 2 Cremetion 3 Removal Irom Stata Department of Important: If eny injury or pace. 5 Other (Specify) Historyland Mem. Park 2-5-00 King George, VA 21. Signet mol Funaral S 22. Name end Address of Fecility M00173 Nash and Slaw F.H. PO Box 336 Ninde King George, VA 22526

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

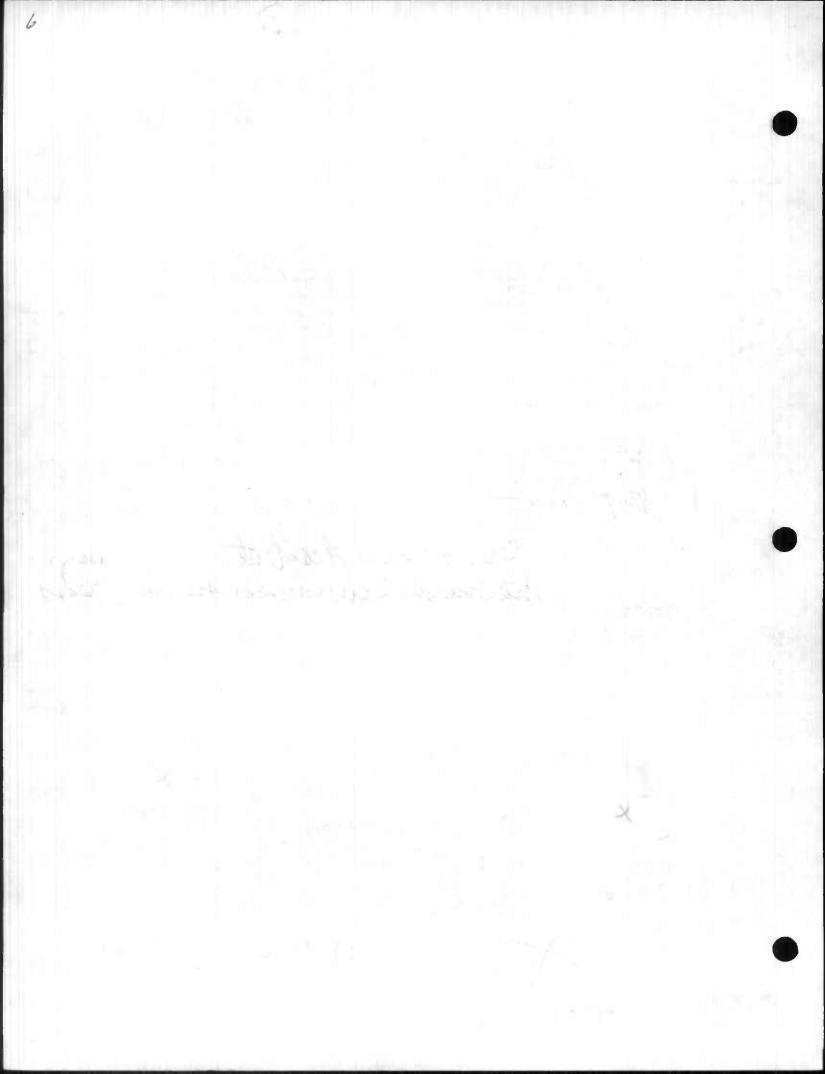
Application of the complete of the Approximate intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or as e consequence of) USO BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown 2 24b. Were autopsy lindings eveilable prior to completion of cause of death? Completed 24a. Was en autopsy performed? page 2 this certificate has 2 X No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Wes case referred to medical examiner? Be 28. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 DOA funaral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Matural To the Hospital or Attendit within 24 hours after death. To the Funeral Director; A completely filled in by the fu death. 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Cartifier Medical (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Date sigged (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) 30. Neme and address of peg LIMP

State Registrar 31. Date liled (Month, Day, Year)

DHMH 16 Rev 6/95

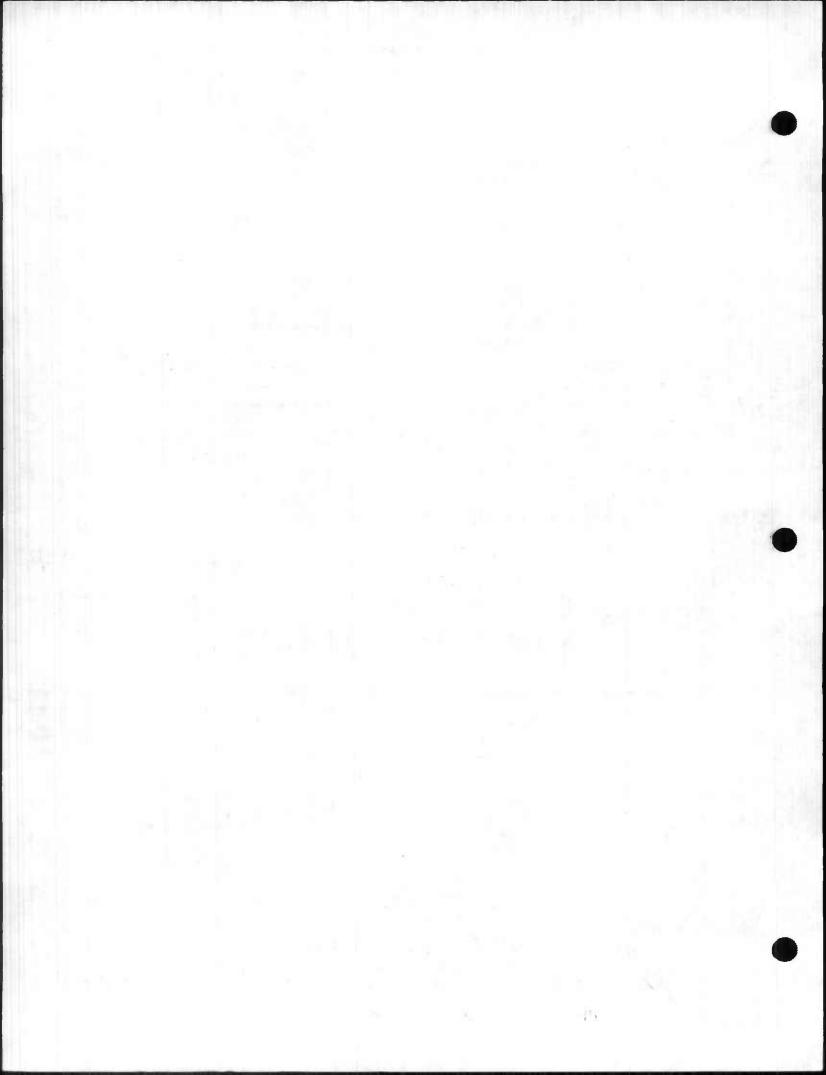
32. Registrar's Signeture



100 1	State of Maryland / Department of Health and Mer	ntal Hygiene 0 0	01	15	6	5
	Certificate of Death	Reg. No.				
lle, Last)	2.	Date of Death		3. Tin	na of	Dea

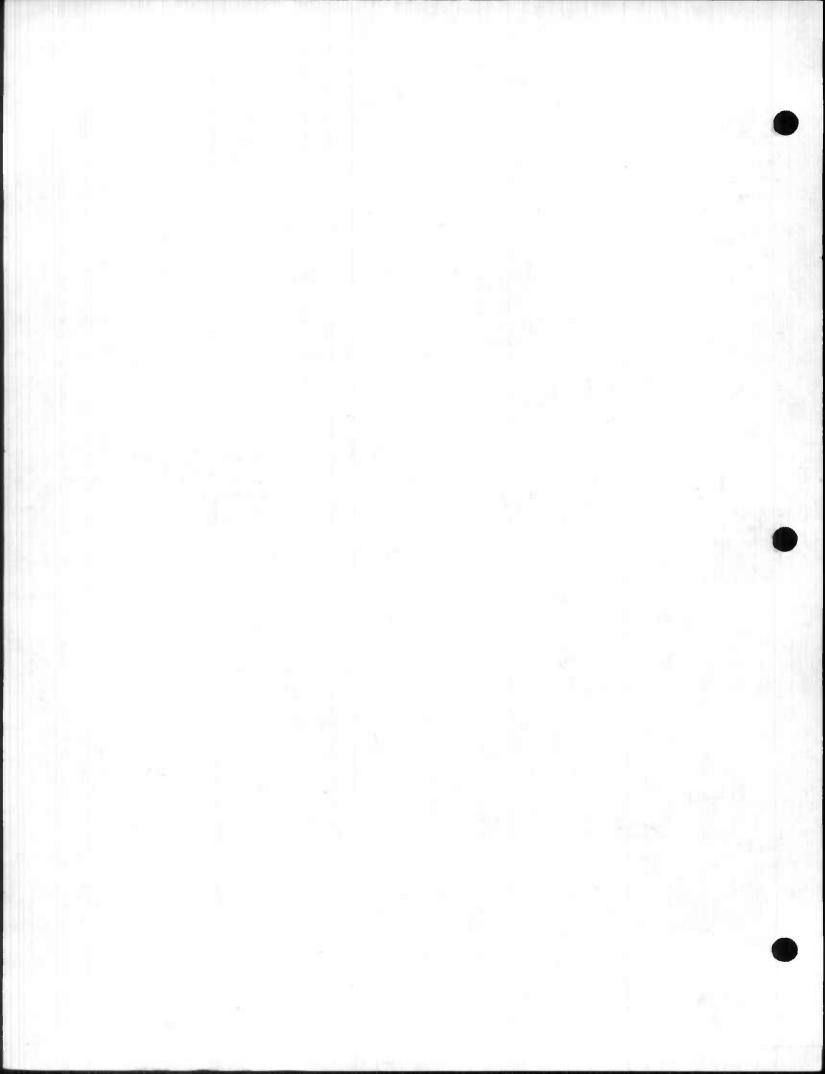
				00/1	mouto of	Dodui		Heg. No.		
	1. Decedent's Name (First, Mid	ldle, Last)					2. Date of De		Vees	3. Tima of Death
Physician	Mary	Dona	Osmo	ond			Month Januar	v 20.	Year 2000	6:55 A.M.
/Medical Examiner	4a Facility Name (If not institut	ion, give street and number	er)			4b. City, Town,	or Location of Deat	4		0.33 H.II.
CAMINITIES	2057 [] ++1	D.41				17				
	3957 Littlesto		Age (in yrs. last	hirthdayl	If Under 1 Yea		Inster Irs. 8. Date of Bi		roll	ann /State or Foreign
Funeral	216-30-4667	1 □ M 2 🖾 F	Call of the Call and		Months Days		lin. (Month, Di	sy, Year)		ace (State or Foreign
Director	Usuat Residence of Decedent	1	67				July 5	, 1932	Mary	yland
ž	10a. Stata 10b. Coun	ty	10c. City, To	own or Loca	ition				10	Od. Inside City Limits
or items 23e or 28e-f ehomoriose must be notified at Puneral Director	V 1 1 0									1 ☐ Yes 2 ☑ No
Director	Maryland Carr	011	Wes	tmins						
1 5	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Count	try?
1 0	3957 Littlest	own Pike			21	158		United	d Stat	es
funer must	11. Marital Status	12. Was Decede Armed Force	nt Ever in U,S.	13. Wa	as Decedent of	Hispanic Origin?	(Specify Yes or No erto Rican, etc.))- 14. Rac	ce - America	
3		arried 1 Tes 25			Yes 2 No		orto riicari, etc.,			
مَ	3 ☐ Widowed 4 ☑ Divorce	If Yes, Give Yeer or Date	\$:	10	1 162 S S 140	Specify:		Specif	y: WII	ite
9	15. Decede	ent's Education	16	Sa. Decede	nt's Usuat Occu	pation		16b. Kind of B	usiness/Ind	ustry
Completed	(Specify only high	est grade completed)		(Give kii lite. DC	nd of work done NOT use retir	e during most of (ed)	working			
O E O	Elementery/Secondary (0-12)	College (1-4c	or 5+)	Flor	ist			Retail	F1 owe	rs
Ö	17. Father's Nama (First, Middle	e. Last)				18. Mother's I	Nama (First, Middle			
8	Charles Alex	ander					Starner		,	
2										
	19a. Informant's Name/Relation		1	9b. Maiting	Address (Stree	et and Number or	Rural Route Numb	er, City or Town	, State, Zip	Code)
Ē		Daughter			Fleming	Road 1	It. Airy,			
3	20a. Method of Disposition		come	of Disposit	tion (Name of tory or other pl	ace)	Jan. 24	20c. Location	- City or Tov	wn, Stata
	1 ☑ Buriat 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other		10		Cemete			Hageret	OWN	Maryland
	21. Signature of Funeral Service	e Licensee	11000		Name and Addi	-	Stauffer			
eny injury or other treumatic event,	1000	1								
	Je XX	July 1							Maryl	and 21771
	23a. Pert1. Enter the tisease, shock, or heart failura. Li	or complications that caus st only one cause on each	sed the death. D	o not enter	the mode of dy	ring, such as card	fiac or respiretory a	rrest,	i	Approximata Intarval Between
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cal	Immediate Cause (Finet disease or condition	$\langle V \rangle$	M							Indous
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Examiner	if any, leading to immediate		D00 10 (01 as	a conseque	silos oi).					•
<u>a</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C	5 /23/24/15/25/25/25/25/25/25/25/25/25/25/25/25/25							
n/Medical	resulting in death) Last	1	Due to (or as	a conseque	ince of):				1	
use es the buriel-transit In/Medical Examir		d								
									1	
9	Part II. Other significant condit	tions contributing to death	but not resulting	g in the und	erlying cause g	iven in Part I.	23b. Did	tobacco uee co	ontribute to	the cause of death?
Physic							127	Yee 2□ No	3 Prob	ably 4 Unknown
be deteched for by Physicia							-			
								en autopsy	24b. Wa	ra eutopsy findings
Completed							pen	ormed?	con	illable prior to npletion of cause leath?
Сотр										
ပိ							10	Yes 25 No	1 🗆	Yas 2 No
8	25. Was case rafarred to medic axaminer?						Death (Check only	one)		
To Be	1 ☐ Yes 2 🗷 No	Hospitel: 1 ☐ tnps	itient 2 ER/	Outpatient	3 DOA	ther: 4 Nursin	g Home \$ Res	idence 6 Ott	her (Specify)
tion:	27. Manner of Death 1 A Naturat 5 ☐ Pend	28a. Data of tr	njury 26t	o. Tima of Injury	28c. Inj	ork?	28d. Describe	how injury occu	rred	
tification		tigation				Yes 2□No				
€	3 Suicide 6 Coute	mined Zoa. Place of	Injury - At homa,	farm, stree	t, factory, office	•	28f. Location (Street and Num	ber or Rural	Routa Number,
Certification:	4 Homicide	building,	atc. (Specify)				City or 10	wn, State)		
	29a, Certifier 1 Certify	ing Physician: To the bes	st of my knowled	loe death o	courred at the	ime data and ol	ace, and due to the	causa(s) and m	annar as str	niad
edical	(Check only 2 Medics	Examiner: On the basis and manner	of examinetion	and/or inves	stigation, in my	opinion, death o	ccurred at tha time,	data and place,	and dua to	tha causa(e)
Medical Cer	29b. Signature and title of certif		statou.		20c Licer	se number	T	20d Date signs	ad (Month (Day Veerl
-	250. Signature prior title or certif	1. 111	×		230. 1100			29d. Date signe	f f	Juy, roar/
	Jumes	mune	mn	12	DZ	744 3	estam	115	12	010
	30. Name and address of perso	n who completed cause of	death (ttem 23a	(Type, Pr	int) A		-	-4-		
	Juhn 1111	Mildet	n 681	PA.	ole Ki	(W)	Show	ules	mo	(2115)
State	31. Pata filed (Month, Day, Yes	r) 32. Regis	strar's Signature		1	1		1		
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State of Maryland / Department of Health and Mental Hygiene 00 04566

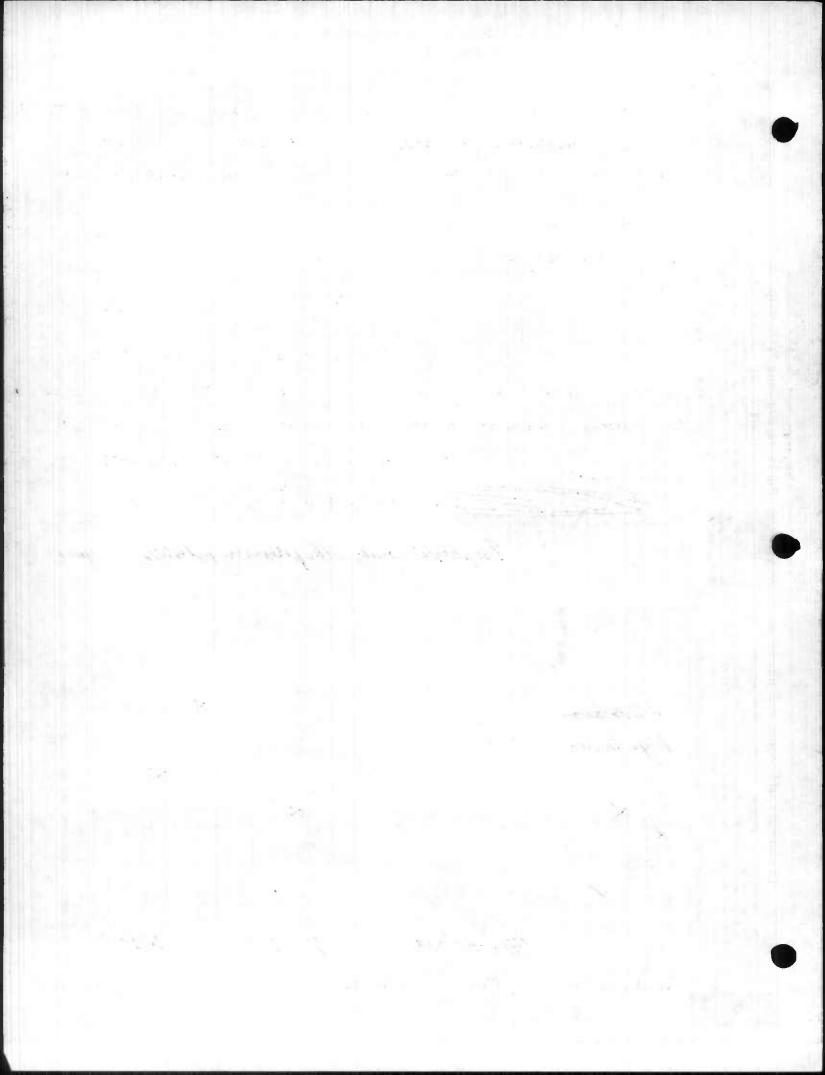
							Certifica	te of	Death			Reg. No.			
			1. Decedent's Nama (First, Middle	a, Last)							2. Deta of De		Mari		Time of Death
	Physici		NAPOLEAN JOSEI	PH PADUA							JANUAR'	Dey 25.	2000		3:18PM
	/Medic Examin		4a Facility Name (If not institution		umber)				4b. City, To	wn, or L	ocation of Deat		County of De		3.10111
4	LAGIIII	ie:	HOLY CROSS HOST	PITAL.				9	SILVER	SPI	RING	M	ONTGO	MERY	
	Funaval		5. Social Security Number	6. Sex	7. Age ((In yrs. last birti		er 1 Yaer	If Under		8. Dete of Bir	th	9.6		(State or Foreign
	Funeral Director		578 52 6093 Usual Residence of Decedent	1∭M 2□ F	89		frs. Months	Deys	Hours	Min.	FEB 28	191	0 1	TALY	
	9 A.		10a. Stete 10b. County		1	IOc. City, Town	or Location							10d. t	inside City Limits
	er death with the Maryland frems 23s or 23s-f show the mast be notified at	Director	MD MONTO	GOMERY		SILVER	SPRING	3							I □ Yes 2∏ No
	5 8 8	듬	10e. Street and Number				10f. Z	p Code				10g. Citize	en of What	Country?	
	23a		8750 GEORGIA A	JE #222A				20910)			IT	ALY		
020	hours after de ursif, or items at Examinar m	by Funeral	11. Marital Status 1 Never Merried 2 Merr 3 Widowed 4 Divorced	12. Wes De Armed F ed 1 Tyes if Yes, G Year or	orces? 20 No live	er in U,S.	If Yes 2 No			Hispanic Origin? (Specify Yes or No- en, Mexican, Puerto Rican, atc.) Specify:			14. Rece - American to Black, Whita, etc. Specify: WHIT		
ĕ			15. Decedent			16a.	Decedent's Us	al Occup	oation			16b. Kind	d of Busines	ss/Industr	у
15	in 72	Completed	(Specify only highes	T			(Give kind of w life. DO NOT	ork done use retire	during mos d)	t of work	king				
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e,	- F E E		20e. Mathod of Disposition			20b. Plece of	Disposition (N	me of		1	Data	20c. Loc	ation · City	or Town,	Stete
Baltimore,	Pages ment of ant: If its ury or o		1 ☑ Buriel 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (S)		State		F HEAV	EN CI	EMETER	1 -	1-29-20				
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			23a. Part1. Enter the disease, or shock, or heert feilura. List	complications that	caused th	ne death. Do n	ot enter the mo	de of dyle	ng, such as	cardiac	or respiretory e	rrest,		App	proximeta ervel Between
	Physician /Medical Examiner	er	Immediata Causa (Final disease or condition resulting in deeth)	a. <u>MA</u>			RHAGIC onsequence of		OKE (C	CVA)		÷		Oni	set and Deeth
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leeding to Immediate cause. Entar Underfug Ceuse (Disease or Injury that initiated evants resulting in death) Last	c			onsequence of								
	death e atter ed for u	Iclai	Pert II. Other algolificant condition	ne contribution to	death hut i	not resulting in	the underlying	cause oi	ven in Pert		23b Did	tobacco u	se contrib	rte to the	cause of death?
P.0.	the sch	Physician/			JOE 111 DD (1	not rooming in	uio viidonynig	outso g.					□No 3□		
Records,	requires been sign should be	Completed by									24a. Was	an autope ormed?	By 24	availab	autopsy findings le prior to ation of cause h?
	0 - 0	E									10	Yes 2E	No	1 □ Ya	s 2 No
Viita	iclan: The certificate rector, pag	Bec	25. Wes case referred to medical						26. Place	e of Dee	th (Check only	ona)			
>	Physician: this certific ral director,	0	examiner? 1 ☐ Yes 2 ☐ No	Hospitel:	Inpatient	2□ ER/Out	patient 3 0	OA OH	her		ome 5 ☐ Resi		□Other /S	necify)	
on of	를 문 교	tion: T	27. Menne of Death 1 Neturel 5 Pendin	28a. Date (Mo.		28b. T		28c. Inju Wo			28d. Describe			poomy	
Division		ertifica	27. Menned Death 1 Neturel 2 Accident 3 Suicide 4 Homicide 28a. Place of Injury - At home, ferm, street, fectory, office 28a. Place of Injury - At home, ferm, street, fectory, office								28f. Location (City or To	Street and wn, State)	Number or	Rural Ro	oute Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical C										d, cause(s)			
	To the within 2 To the comple	Me	≥ 29b. Signetura and title of certifier								signed (Mo	onth, Day	Year)		
	F 5 F 0		1 pos					D000	054566	5		JANU	JARY 2	6, 2	000
	4	ŀ	30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)												
	1		SUNITA BHOG	AVILLI M.	D. 8	609 2NI		SILV	ER SPI	RING	, MD 20	910			
	Sta Registr		JAN 31		Degistrar's	s Signature	1. do	nks							



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

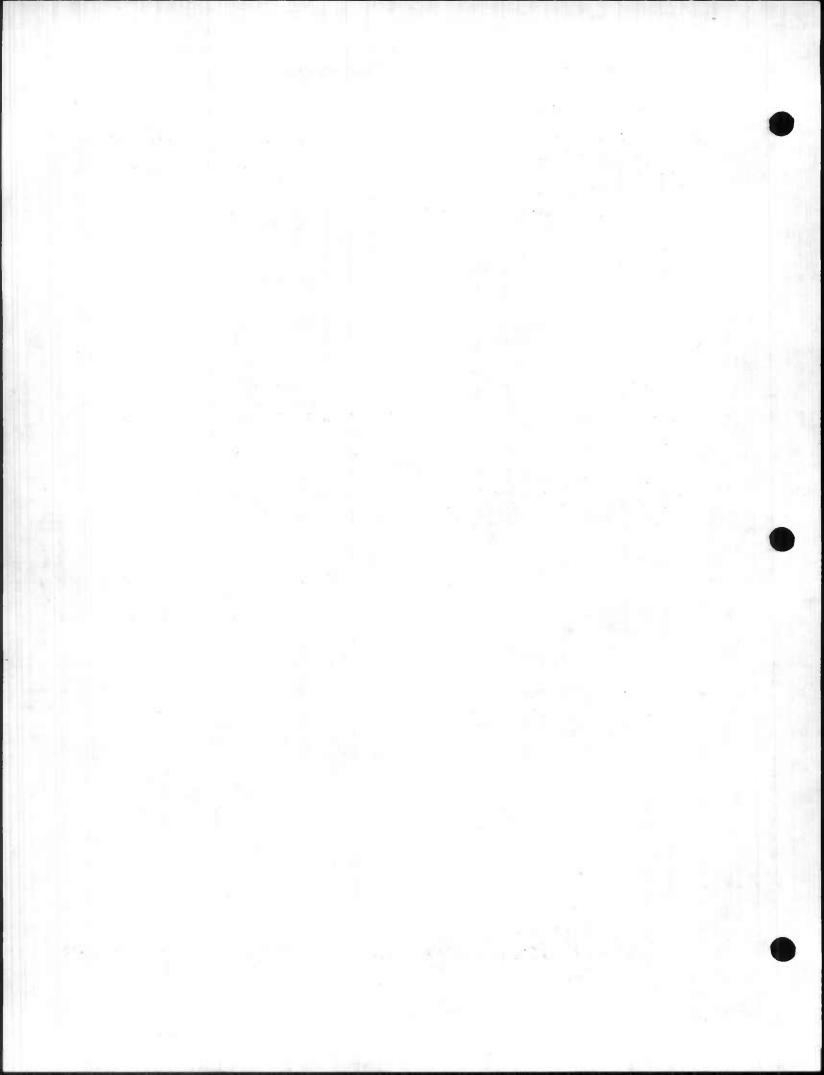
State of Maryland / Department of Health and Mental Hygiene 0 4567

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×	_	Decedent's Nam	o (r mort minor	ile, Last)								2. Date of Deat Month	th Day	Year	3. Time of E
hysician /Medical	_	Herman		0	Scar		P-	rice				Jan	-	2000	8:20
xaminer	4.0	Facility Name (If not institutio			n <i>ber)</i>	-	2200		4b. City, To	own, or Lo	cation of Death	7	ty of Death	
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Department Important: I any injury o	- 1	Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601													
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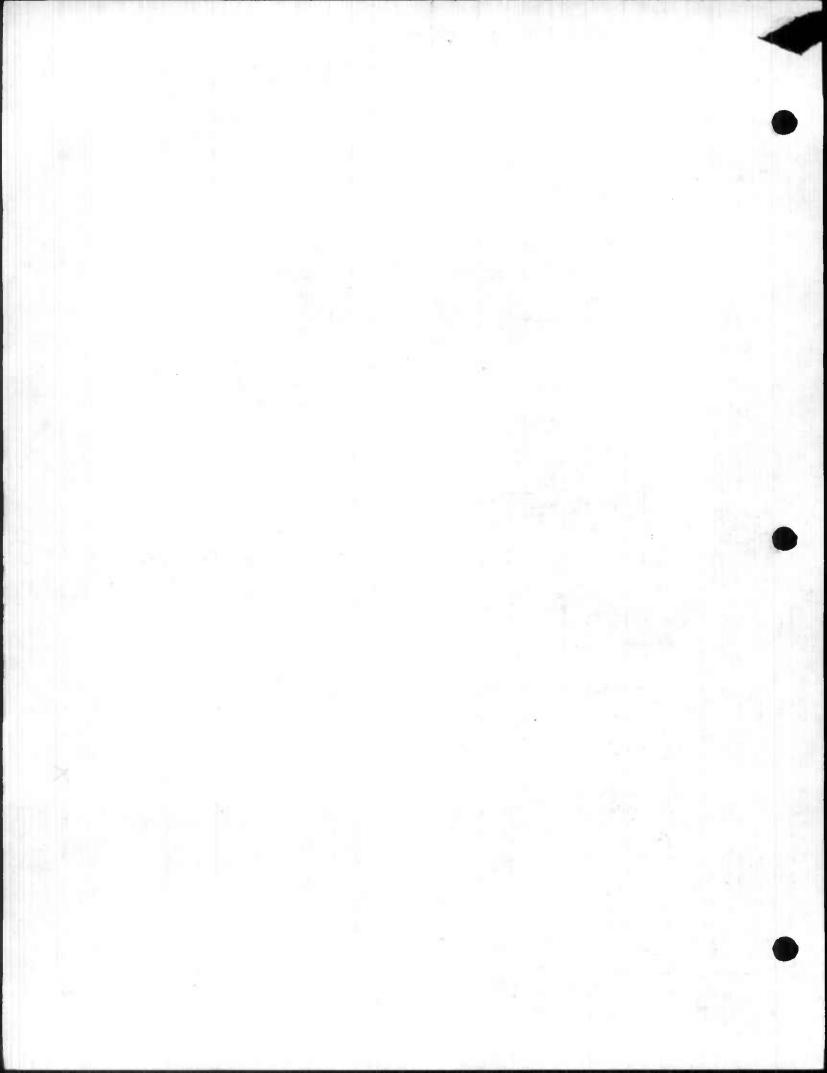


State of Maryland / Department of Health and Mental Hygiene 00 04568

			Certificate of Death	Re	g. No.	7000
0		Decedent's Nama (First, Middle, Last)		2. Data of Death	1	3. Time of Death
	Physician /Medical	Young Min Pak		February	2, 2000	2:40pm
	Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, To	wn, or Location of Death	4c. County of Death	-
		13408 TANGIER PLACE	Rock	ville	Montgomer	У
	Funeral Director	5. Social Security Number 220 72 3829 6. Sex 12 M 2□ F 6.5	oirthday) If Under 1 Year If Under 3 Yrs. Months Days Hours	Min (Month Day	9. Birthp (Coun 4, 1934 K	blace (State or Foreign itry) COREA
	rdeeth with the Mayfand were 23e or 28e-f show in must be notified at therail Director	MD MONTECOMEDY DOCKT	wn or Location		11	0d. Inside City Limita 1 ☐ Yes 2 ĀNo
	or 28e-f s be notified Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	itry?
	n with		20853	U	SA	
21215-0020	urs after str. or th Examin by Fu	3 ☐ Widowed 4 ☐ Divorced	13. Was Decedent of Hispanic Origit Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☒ No Specify:	jin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Americ Black, White, a Specify: AS	
20	ed within 72 ho ygiene. we than "naturn t, the Medical. Completed	15. Decedan('s Education (Specify only highest grade completed)	ia. Decedent's Usual Occupation	of working	6b. Kind of Businass/Inc	dustry
21	Med of	(Specify only nignest grade completed) Etamantary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)	Of WORKING		
2	the state of	12	MECHANIC		TRANSPORT	ATION
P	be fill the	17. Fathar's Nama (First, Middle, Last)		r's Nama (First, Middle, Mi	aiden Sumame)	
yla	Ment Went To To		MAI	N SOON CHOI		,
, Maryland	aith and 2 sho aith and 27 is me er traume		9b. Mailing Address (Street and Number 3408 TANGIER PLACE			Code)
Baltimore,	Pages 1 in sent of He mut. If Nem ury or other	1X Burial 2 Cramation 3 Removat from State	of Disposition (Name of tery, crematory or other place) MEMORIAL PARK	Data 20	Oc. Location - City or To	
Balti	pemit. Departm Importar any Inju	21. Signature of Fundral Service Licensee	22. Nama and Address of Facility			HAMPSHIRE
		Part1. Enter the disease, or complications that deused the death. Do shock, or heart failure. List only one cause on each line.	AVENUE SILVER			Approximate
	Physician /Medical Examiner	Immediate Causa (Final diseasa or condition rasulting in daath)	hac an	hytlim	· q	Approximata Intarval Between Onset and Death
Box 68760,	death certificate be associed e attending physician and ad for use as the bunat-transit sician/Medical Examiner	Cause (Disaase or Injury that initiated evants rasulting in death) Last	a consequence of):	Film	Marjan	-> grs
P.O.	the set the		in tha underlying cause given in Part I.	23b. Did tob	pacco una contribute to	the cause of death?
of Vital Records,	been sign should be			24a. Was an perform	ed? avi	ere autopsy findings ailable prior to mpletion of cause death?
ď	The law ate has page 2	1		1 ☐ Yas	s 20 No t	∃Yas 2□ No
ta	certificate rector, pag	25. Was casa rafarred to medical	26 Place	of Death (Check only ona	()	
>		examiner? 1 Yas 2 No Hospital: 1 Inpatient 2 ER/C	Othor	rsing Homa 5 Rasiden		iv)
	Attending Physical death. ector: After this by the funeral diffication: To		Tima of Injury at Work? M 28c. Injury at Work? 1 Yes 2 I	28d. Describe hov		
Division	tal or Attending P rs after death. al Director After t led in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be datamined 28a Place of Injury - At homa, building, atc. (Specify)	farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura Stata)	I Route Number,
	Hoepi 24 hour Funer stely fill dicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge one) Certifying Physician: To the best of my knowledge one one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certifying Physician: To the best of my knowledge one of the certification of the certi	ge, death occurred at the tima, data and and/or investigation, in my opinion, death	d place, and due to the cau th occurred at the tima, dat	use(s) and manner as si ta and place, and dua to	tated. the cause(s)
	within To the comple	29b. Signature and titla of cartifiar	29c. License number		d. Data signed (Month,	Day, Year)
	1	Wantel Kining My	Sician 1) 40	7071	2-3-	-00
	>	30. Name and address of person who completed cause of daith (New 23a DANIEL KIM M.D. 121 CONGRESSIONA	0	ILLE, MD 20	853	
	State Registrar	31. Data filed (Month, Day, Year) FEB 0 4 2000 32. Registrar's Signatura	G. Sparks			

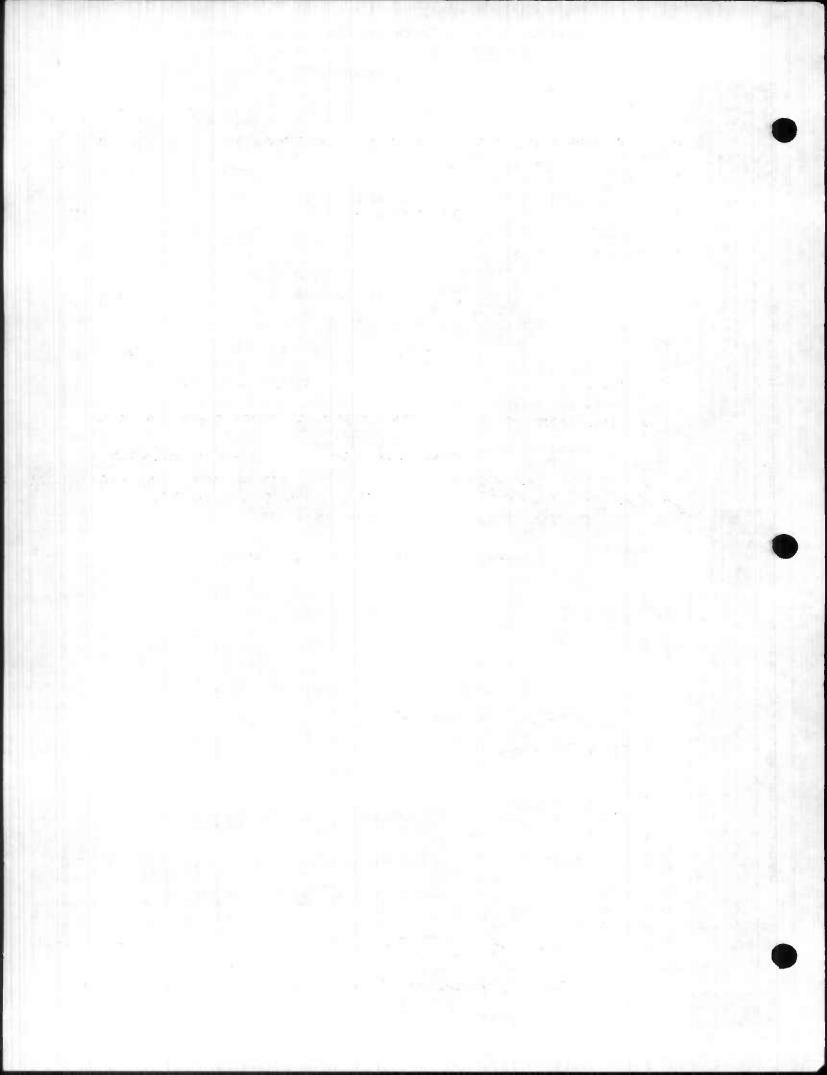


Ame	end #26,2	State of Maryland / Department of Health and Mental Hygiene [] [] [] 569 3/2000, BMW, Montg. Co. Certificate of Death Reg. No.
	Physician	I. Decedent's Name (First, Middle, Last) Fannie Arterbridge Parker 2. Date of Death Month Day January 14, 2000 5:30 AM
	/Medical Examiner	la Facility Name (If not institution, give street and number) 1609 01d Bay Lane 4b. City, Town, or Location of Death Severn Anne Arunde1
	Funeral Director	5. Social Security Number 156-18-6138 6. Sax 1 Months Days Hours Min. 7. Age (In yrs. last birthday) Hunder 1 Year Hunder 24 Hrs. B. Date of Birth (Months Days Hours Min. Oct. 21, 1897 Chlowan Co, N
	r 28a-f show	Journal Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita NC Chowan Edenton ₩Xves 2 □ No
	th with the 23e or 28e ast be not	10e. Street and Number 207 E. Albemarle Street 27932 10g. Citizen of What Country? USA
020	72 hours efter deeth with the Meryland natural; or items 23s or 28s f show acel Examiner must be notified at etch by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 24 No 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc. 17. Specify: 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 11. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Armed Forces? 16. Race - American Indian, Black, White, etc. 17. Specify: 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 11. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent E
21215-0020	within then.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Instructor Public School
TO	d 2 should be filed th end Mental Hygis 7 la marked other treumatic avent, To Be Cc	7. Father's Name (First, Middle, Last) Rhoden Arterbridge 18. Mother's Name (First, Middle, Maiden Sumame) Julia Brown
	도들어노	19a. Informant's Name/Relationship (Type, Print) Andrea Cunningham (Granddaughter) 1609 01d Bay Lane Severn, MD 21144
Baitimore,	permit. Peges 1 en Department of Heal Important: if flem 2 any Injury or other DRSs.	No. Method of Disposition 1 Disposition 2 Commetter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 Commeter 20c. Location - City or Town, State 2 Commeter 20c. Location - City or Town, State 20c. Location - City or Town, S
Bai	permit. Pe Department Important: any injury phose.	22. Signatury Funeral Service Licensee Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310
4	Physician /Medical Examiner	Approximete holds asset or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, approximete interval Between Onset end Death Approximete Interval Between Onset end Death Immediate Cause (Finet disease or condition resulting in death) Due to (or as a consequence of):
x 687	certificate be executed nding physician and use as the buriel-transit n/Medical Examiner	b
o.	that the deeth certificated by the attending professional for use as a Physician/Me	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did 1obacco use contribute to the cause of death?
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_	To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Withir Song M	96. Signature and title of certifier 29c. License number D41955 1-14-2000
		O. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Rebecca Elon MD 479 Jumpers Hole Rd #304 Severna Parkento
	State Registrar	11. Date filed (Month, Day, Year) FEB 03 2000 32. Registrar's Signature 4. Sparks



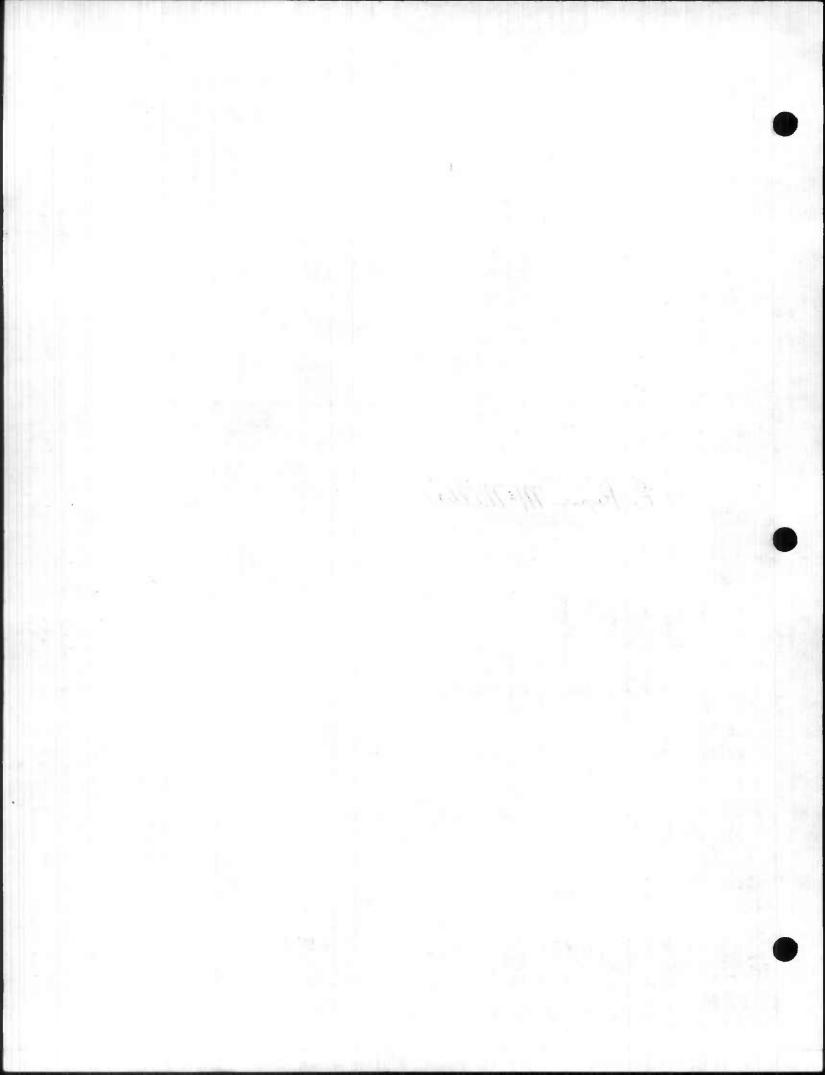
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/Medical Examiner	4a Facility Neme (If not institution, g	11			4b. City, To		ation of Deatl		ty of Death				
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by Funeral Director			WASHING	TON DC						1 XYes 2 No			
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Funeral Director													
a a	430 QUACKENBOS S							USA					
The	11. Meritel Stetus	12. Was Decedent E Armed Forces?	Ever in U,S. 13	If Yas, specify Cuban, Maxican, Puarto				- 14. Race - American Indien, Black, Whita, atc.					
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To	SPIRO PASSAS				ALEX	ALEXANDRA PONTIKI							
Г	19a. Informant's Name/Ralationship	(Type, Print)	19b. Mai	ling Addrass (Stre	et and Numb	er or Rural	Routa Numb	er, City or Tow	n, Stata, Zip	Coda)			
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	1 Burial 2 ☐ Cremation 3		GLENWOOD	amatory or other p		3_3	3_2000	MACHIN	VASHINGTON, DC				
	4 Donation 5 Other (Spe					1							
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	27. Mannar of Death 1 Anatural 5 Panding	28a. Data of Injui (Month, Da)	y Year) 28b. Tima Injury	of 28c. In	jury at vork?	2	8d. Dascribe	how injury occ	urred				
To the Funeral Director: After completely filled in by the funeral Medical Certification:	2 Accidant Invastigation M 1 Yas 2 No												
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a C		1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manna							mannar as s	stated.			
edical		(Check only 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s)											
M	29b. Signatura end fitte of continue 29c. License number						29d. Data signed (Month, Day, Year)			, Day, Year)			
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7	30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) 13952 Boztomon & AVE												
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State	31. Data filed (Month, Day, Year)	32. Registra											
gistrar	JAN 312	UUO Arne	va G.	Louis	21								



	100				State of	Marylan		tificate of	Death	тепіаі пу	Reg. No.	Q L	176		
			1. Decedent's Nema (First, Middle, Last)								2. Date of Death Month Dev Y		3. Time of Death		
я	Physician	N.	Mussical I Detroical								Dey	Year	(05		
4	/Medica	4	Muriel J. Patrick 4e Fscility Nama (If not institution, give street end number) 4b. City, Town, or Lo									000	6:25		
4	Examine														
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Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours af Department of Heelth and Mental Hygiene. Important: if ham 27 is marked other than "natural", or my highly or other traumatic award, the Marical Examples.	Wild and and and and and and and and and an	5	Clother Nat y 70000	10019 (0-12)	3	401 017	Nurse				Medica	edical			
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Baltimore,	Department Findoctan	2	1. Signature of Fu	nerel Service Llc	ensee			. Neme end Addre							
m	8858	P. Ryan Mª Millian Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring,											1/D 0000		
		2	3a. Pert1. Enter th	ne disease, or co	mplications that ca	used the deet	h. Do not ente	er the mode of dvi	ing, such es cardiec	or respiratory a	Silver mest.	Sprin	Approximete Interval Between		
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2	red In by		3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, streef, fectory, offica building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	ins after death. The Director: After it lied in by the funeral Certification:														
	hours uner	29	9a. Certifier (Check only	1 Certifying F	Physician: To the b	est of my kno	wledge, death	occurred at the t	ime, date and place, opinion, deeth occur	and due to the	cause(s) and m	enner as si	ated.		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2 Medical Certification: To Be Comp		one)	Z I MOURCEI EX	and mann	er stated.	mon snoor inv	esugenon, in my	opinion, deeth occur	ieu at the time,	, vate end pisca,	and due to	nio causo(s)		
	To the Com		29b. Signature and title of certifier 29c. License number D36252							_	ned (Month, Dey, Year)				
	16									FOBENARY 02, 2000					
	(2)	20													
	(10)	30	30. Name and address of person who completed cause of death (flem 23a) (Type, Print) STEVEN T. KARIYA, MD, 11501 GEORGIA HVE. ST. 575 WHENTON MD 20902												
		2.	Date filed (14	h Day Varet	עוייון דין	1001	400CGI	-		3.10.110	,,,				
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	Registrar		1-	ED AS	2000		1	7							

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Day **Physician** FEBRUARY 3, 2000 DONALD PELLER 3:50 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days M 2DF Months Yrs. Director 098-05-7972 APRIL 22, 192B NEW YORK 76 Usual Residence of Decedent r 28a-f ahow 10a Stata 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 Norma 23a PISGAH ROAD, 9727 MT. #1004 20903 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1XOX'es 2 □ No If Yes, Giva Year or Datas: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 ahould be filed within 72 hours after c. Department of Health and Mental Hygiena. Important: if Itam 27 is marked other than "natural", or Itam any Injury or other traumatic avant, the Medical Estimated backs. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3XWidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SALESMAN SALES 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) MAX PELLER EVELYN MERKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) STEWART PELLER - SON 118 CLEARWATER DRIVE, FALMOUTH, ME 04105 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from Stata 4 □ Donation 5 □ Other (Specify) OLNEY, MARYLAND JUDEAN MEMORIAL GARDENS 2-4-00 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility HINES-RINALDI FUNERAL HOME, INC. ()lla bru 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Finat diseasa or condition resulting in death) /Medical CORONARY ARTERY DISEASE Examiner Due to (or as a consequence of): Physician/Medical Examiner DIABETES physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) 68760 Due to (or as a consequence of): USB BS Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. þ

Completed

25. Was case referred to medical axaminer?

1 Yas 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

Du

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28b. Tima of Injury

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 200No 1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and little of certifier

5 Pending investigation

6 Could not be detarmined

29c. License number

29d. Data signed (Month, Day, Year) FEBRUARY 3, 2000

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) LARCA

Hospital:

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year)

FEB 04 2000

MD 7600 32. Registrar's Signatura

CARROLL AUE TAXOMA PARK, MARYUND doorks

Registrar

State

page 2 has

this funaral

After

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun.

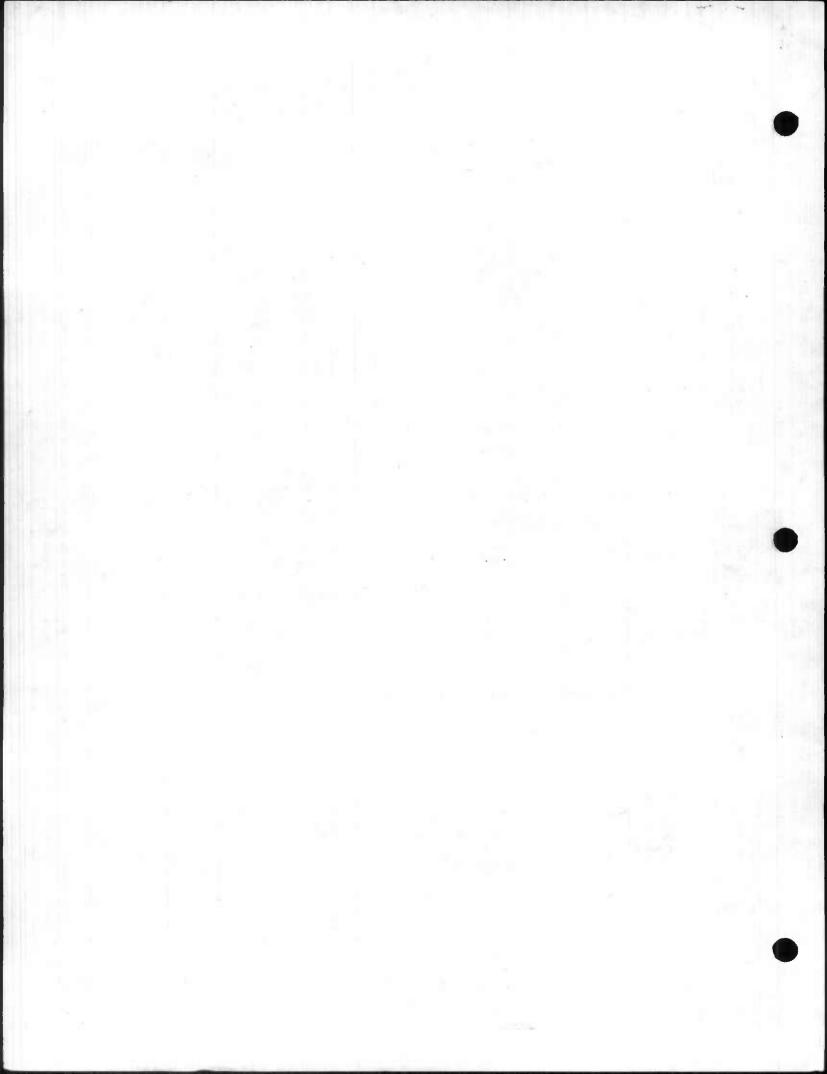
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8

To

Certification:

Division of Vital or Attending Physician:



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death Month 23, 2000

Physician /Medical Examiner

RONALD D. PHELPS

1. Decedent's Name (First, Middle, Last)

JANUARY

1300 PM

10d. Inside City Limits

Approximate Interval Batween Onsat and Death

White

1 ☐ Yes 2 No

Funeral Director

must be n the Medical Exeminer. filed within 72 hours after

permit. Pages 1 and 2 should be in Department of Health and Mental important: If them 27 is marked or any Injury or other traumatic eve

3altimore, Maryland 21215-0020

Box 68760.

P.O.

of Vital Records.

Division

Physician /Medical **Examiner**

certificate be executed physician s the burial 080 8 signed to Completed page or Attanding Physician: Be Medical Certification: To this After death. after death Director:

5. Social Security Number 227-68-5762 10a. Stata Maryland Directo 10e. Street and Number Funeral 11. Marital Status à Completed Be Roland W. 20a Mathod of Disposition Immediata Causa (Finat disaasa or condition rasulting in death) Examine Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Physician/Medical þ

4b City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death 305 MARYLAND AVENUE NORTHEAST GLEN BURNIE ANNE ARUNDEL If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. lest birthdey) Birthplaca (Stata or Foraign Country) XXM 2□F 53 Yrs. 1, 1946 Virginia Usuel Residence of Decedent 10c. City, Town or Location 10b. County Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 305 Maryland Avenue 21060 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 M Yas 2 □ No If Yes, Giva Year or Dates: 1967–1970 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 20 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Accountant Halethorpe Extrusions 18. Mothar's Nama (First, Middle, Malden Sumama) 17. Father's Nama (First, Middla, Last) Phelps Nita Mae Bragg 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Carol A. Phelps (wife) same as #10 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, State 1X Burlal 2 Cremation 3 Removal from Stala Arlington National Cemetery 2/2/2000 Arlington, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice License Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or heert failura. List only one cause on each lina. Dua to (or as a consequence of): Dua to (or as a consequence ot) Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24a. Was an autopsy

24b. Wera autopsy tindings available prior to complation of cause of death? 1 XYas 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa Rasidance 6 Othar (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA YYas 2□ No 28c. Injury at Work? Manner of Death 28b. Tima of 28d. Dascribe how injury occurred injury 546, ect hanged self
281 Cocation (Street and Number or Aural Acuta Nymber, NG
City or Town, State) 30 5 Mary land Aue NG
City of Firms and 1 Natural 5 Panding 1 ☐ Yas 29 ☐ No Found 1-23-60 Found 1154AM invastigation 2 Accident 3 Suicide ☐ Homicida 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) home Gen Burnie, Md 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signatura and titla of certifian O.C.M.E. JANUARY 24, 2000

hutz no 30. Nama and addrass of person who

completed causa of death (Item 23a) (Type, Print)

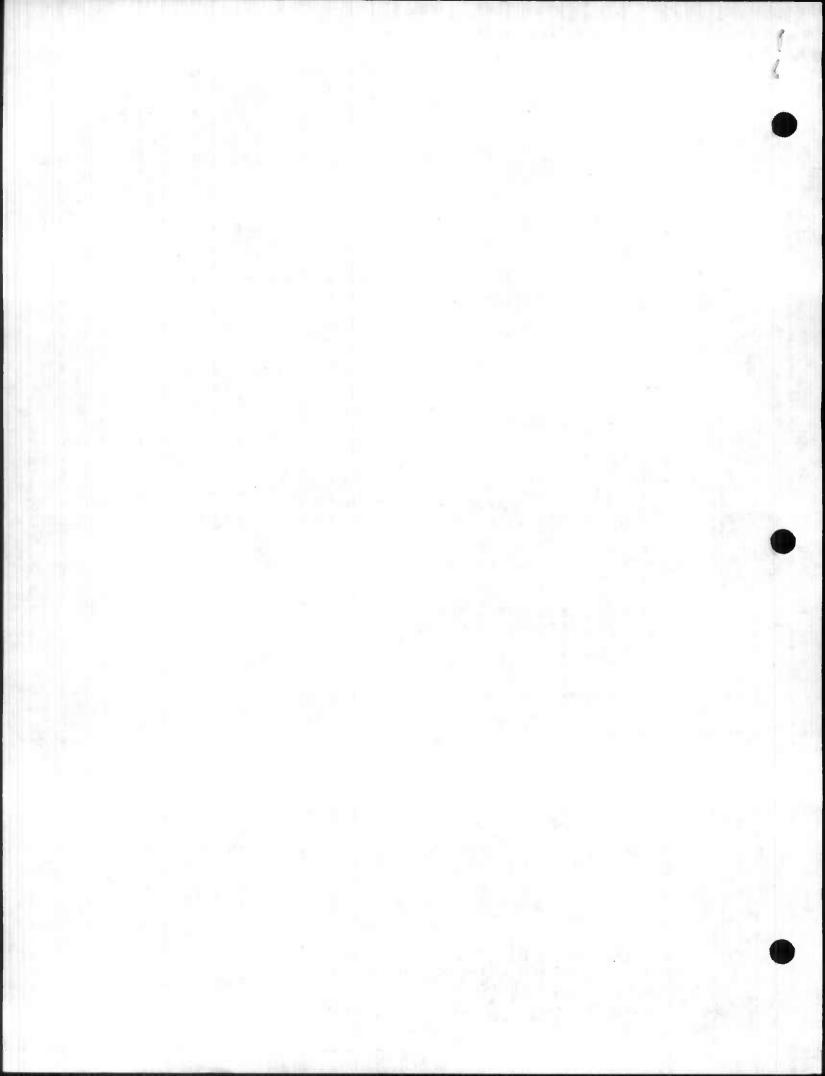
111 Penn Street, Baltimore, Maryland 21201 hute MD

State Registrar

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To the Hospital or within 24 hours aft To the Funeral Di completely filled in

ennis



State of Maryland / Department of Health and Mental Hygiene 04574 Certificate of Death 1. Decedent's Name (First Middle Last) 2 Data of Deeth 3. Time of Death Month Physician POLACK 8:15 PM HARRIET Ε. 24 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL CROFTON CROFTON CONVALESCENT HOME If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□M 2₩F Months Deys Hours Min Yrs MARYLAND 1/30/1921 78 Director 216-12-6358 Usual Residence of Decedent 10e. Steta 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Exerciner must be notified at 1 Yes 2 No Director PRINCE GEORGES BOWIE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Berns 23a USA 20715 2709 FELTER LANE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yaar or Detes: 14. Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Merital Stetus Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Merried b Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: py WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 18b. Kind of Business/Industry Hygiene. Cotlege (1-4or 5+) Elementary/Secondary (0-12) U.S. GOVERNMENT EDITOR ith and Mental Hygid 27 is marked other r traumatic event, to 18. Mother's Name (First, Middla, Maiden Sumama) 17. Fether's Neme (First, Middla, Last) Be ANNA ROTHMAN LOUIS GREENSTEIN 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19e. Informant's Name/Reletionship (Type, Print) 2709 FELTER LANE, BOWIE, MARYLAND 20715 Department of Health Important: If Item 27 (HUSBAND) MAX POLACK Saltimore, 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition

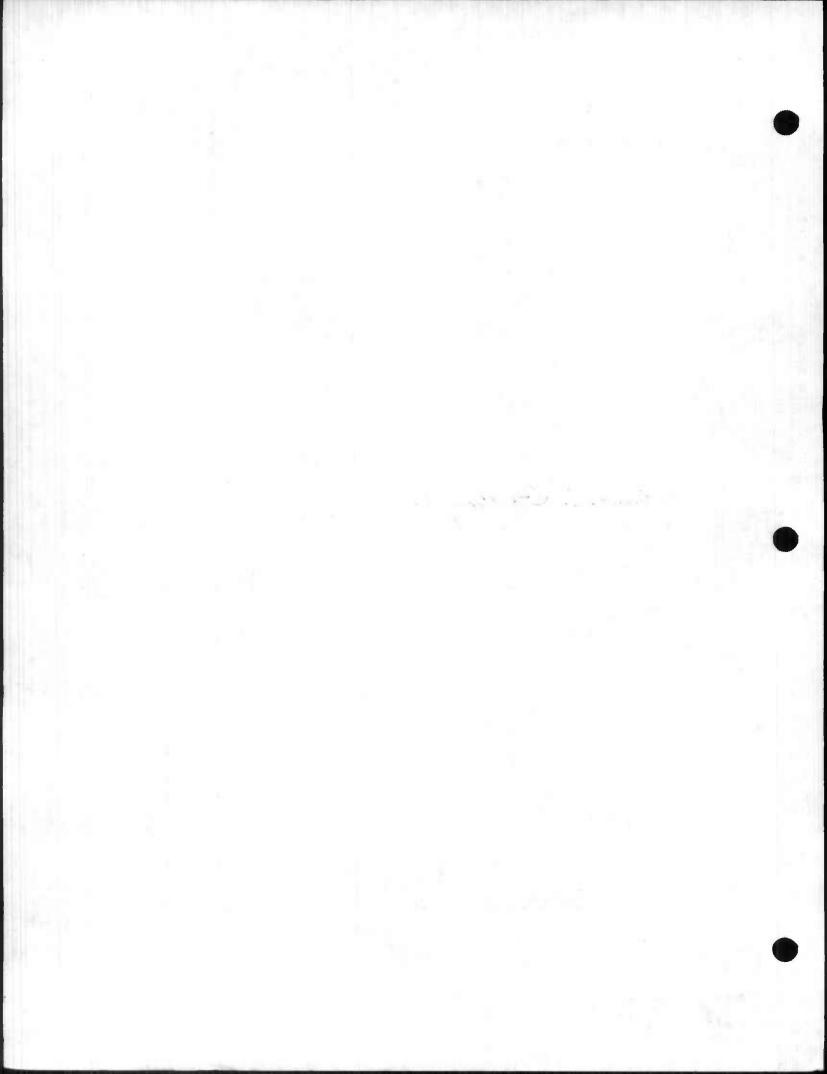
1 → Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Dete ÷ 4 ☐ Donetion 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 1/28/00 OLNEY, MARYLAND 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart feiture. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiec or respiretory errest, Approximete Interval Between Onset and Death **Physician** tramediete Cause (Final disease or condition resulting In death) /Medical ATHEROSCLEROTIC CARDIOVASCULAR DISEASE YEARS Examiner Due to (or as a consequence of) Physician/Medical Examiner ADVANCE PARKINSON'S DISEASE YEARS The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last use as the buriel-tran Due to (or as a consequence of): and Box 68760, attending physician Due to (or as a consequenca of) P.O. 1 23b. Did tobacco usa contributs to the cause of death? Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No 3 Probably 4 Unknown eigned by ISCHEMIC COLITIS þ Records, 90 24b. Were sutopsy findings available prior to completion of causa of death? page 2 should Be Completed 24e. Was an autopsy performed? this certificate has 1 ☐ Yas 2 X No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Wes case referred to medical 26. Piece of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes ZXNo s efter death.
I Director: After this id in by the funeral di 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) completely filled in by 4 Homicide To the Hospital within 24 hours e To the Funeral D 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D20108 JANUARY 26, 2000 12 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 14300 GALLANT FOX LANE, SUITE 222, BOWIE, MD 20715 RAKESH ARORA, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State oaks

DHMH 16 Rav 6/95

Registrar

JAN 31 2000



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death **Physician** Jan 31, 2000 ELENORA POWELL 8:30 Pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Washington Adventist Hospital Montgomery | HUnder 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 9. Birth (Country) | 1. Nov 22, 1941 | Virginia 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foraign Country) **Funeral** Days Months 1 ☐ M 2 🖾 F 219-36-8770 58 Director **Usual Residence of Decedent** 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits - worke x 28e-f ehow Director 1 Yas 2 No Laurel Prince George Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? se filed within 72 hours effer death with it hygiene.
I other than "natural", or frams 23s or it vent, tha Wedden Emminer man be I seen, that we deat Emminer man be I. 806 Maple Ave, U.S.A. 20707 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No N Yes, Give Year or Dates: 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, White, atc. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Presser (TRS) llth Grade 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) or Health and Mantal H I ham 27 is marked off George Clay Mamie Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 806 Maple Ave, Laurel, Md 20707 Charles E. Powell Sr. Baltimore 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Pages hant of h Department of Important: If Ih any injury or o 1 General 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/8/00 Laurel, Md Md National Cem. turn of Funeral Service Lipus 22. Nama and Address of Facility Snowden Funeral Home P.A. 20850 nowd 246 N. Washington St, Rockville, Out 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onsat and Daath **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 1 month Examiner Due to (or as a consequence of) Examiner physician and the burlei-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in a lated exercises. Due to (or as a consequence of) Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 997 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? certificate hes 2 No 1 ☐ Yes 28 No 1 ☐ Yes å 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 20 No edical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Mospital or Attending Pt within 24 hours etter deeth.

~To the Funeral Director: After the completely filled in by the funeral 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Natural
Accident 5 Pending investigation njury 1 Yas 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

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29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 08

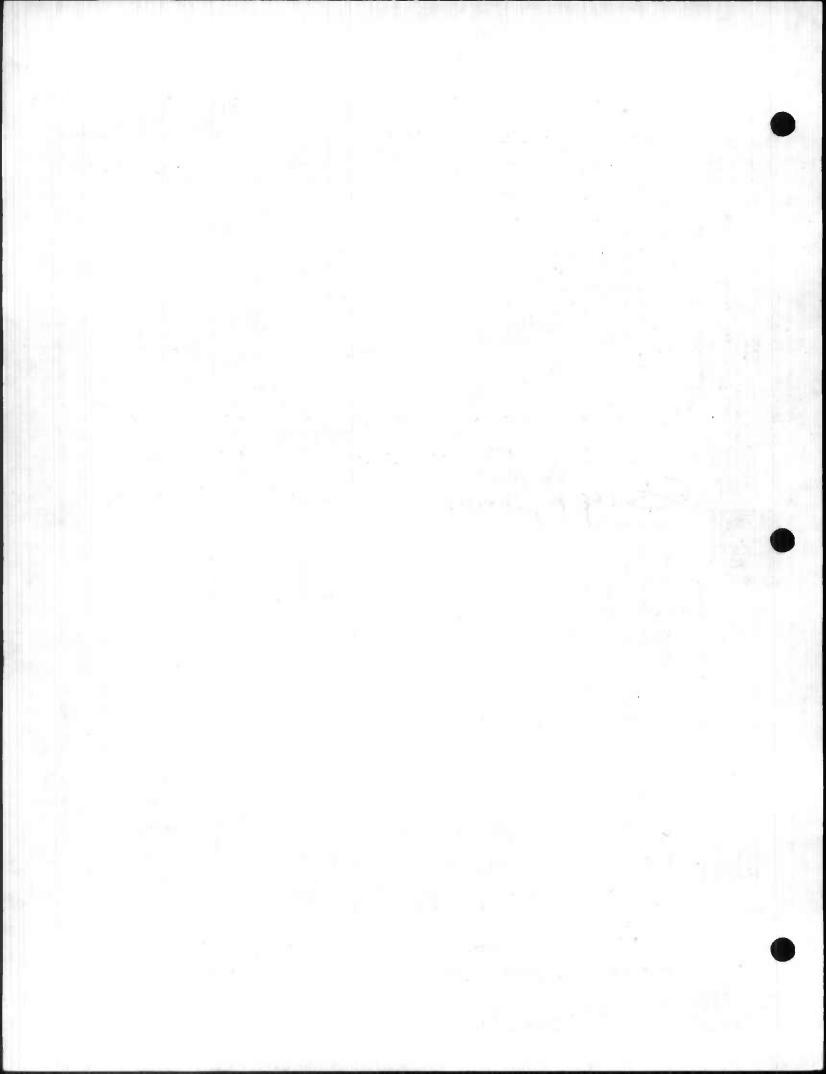
VANKAR AMAN MA 32. Registrar's Signature

re and address of person who completed cause of death (Item 23a) (Type, Print) CIRKENBELL

29c, License number

29d. Data signad (Month, Day, Year)

HAMNER PARKNRY



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int \) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month MARUARET P

4a Facility Name (If not institution, give street and number 1810 28 2000 4b. City, Town, or Location of Daath 4c. County of Death Montgomery General Hospital Olney Montgomery 7. Age (In yrs. lest birthdey) If Undar 1 Yaar | If Undar 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dev. Year) 1 □ M 2 1 F Months Deys Hours Min. Yrs. 577-01-2322 96 Sept. 7, 1903 Virginia Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20910 USA 1609 North Springwood Drive 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yaer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Black, Whita, atc. 1 □ Navar Married 2 □ Married 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Manager Food Service 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Fathar's Nema (First, Middla, Last) Anna Jones Alexander Horne 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 2410 Olson Street, Marlow Heights, MD 20748 Dorothy P. Crusan/Niece 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Removel from State 1/29/00 Alexandria, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final · ACUTE MYOCARDIAL INFARCTION disease or condition resulting in deeth) FAILURE CONGESTIVE HEART 10 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequenca of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Wes cese referred to medical exeminer? 28. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28h Time of 28c. Injury et Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident

Physician /Medical Examiner

Department of Important: If It any Injury or o

Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0020

Directo

Funeral

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Examiner 89

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that the death certificete be executed Division of Vital Records, P.O. Box 68760, signed by the a d be detached t should should certificate has t director, page 2 s Hospital or Attending Physician: this Aftar efter death. Director: Aft

29e. Certifier

3 ☐ Suicide

4 Homicide

t 🗵 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

29b. Signeture end title of cartifier

29c. Licansa number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

2000

6 Could not be determined

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Ridge 10794

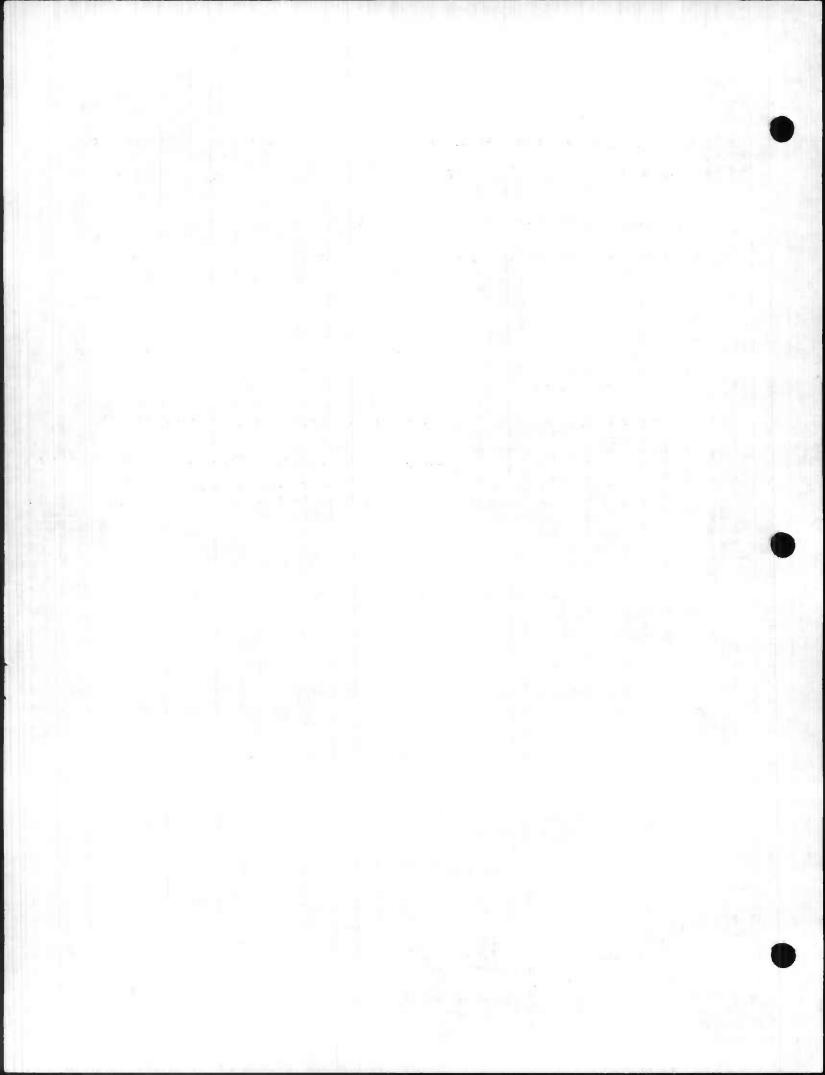
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State Registrar

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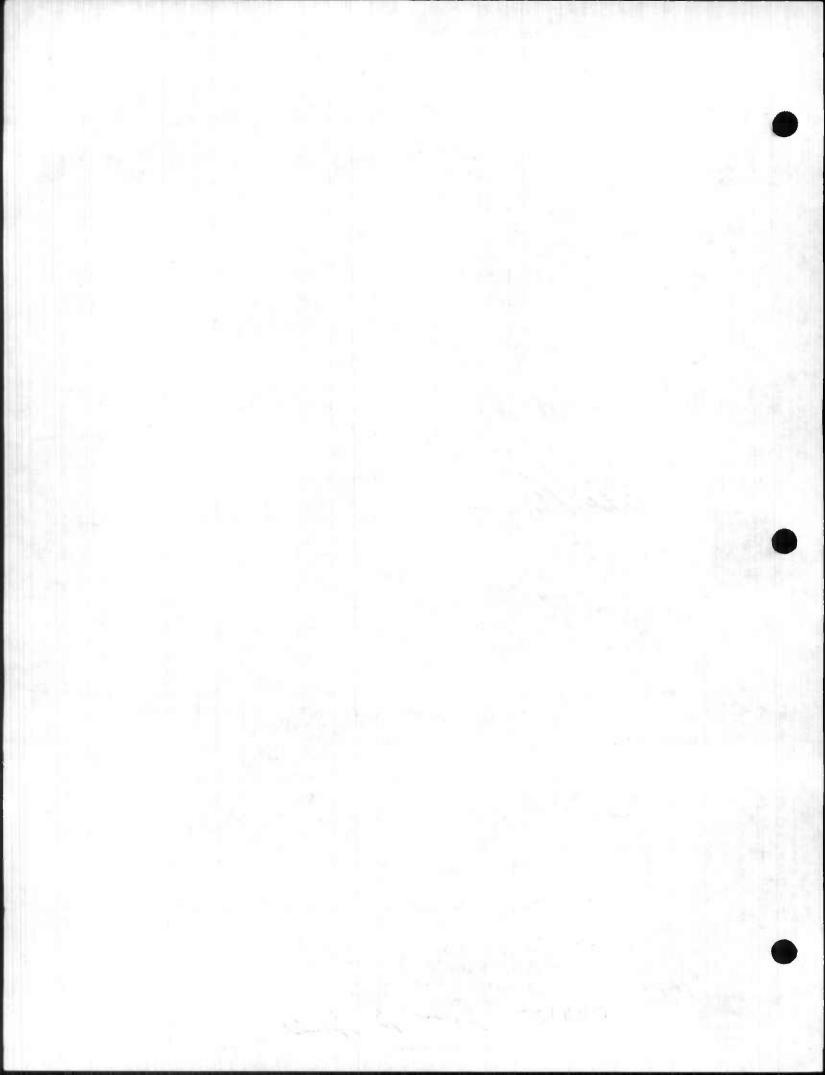
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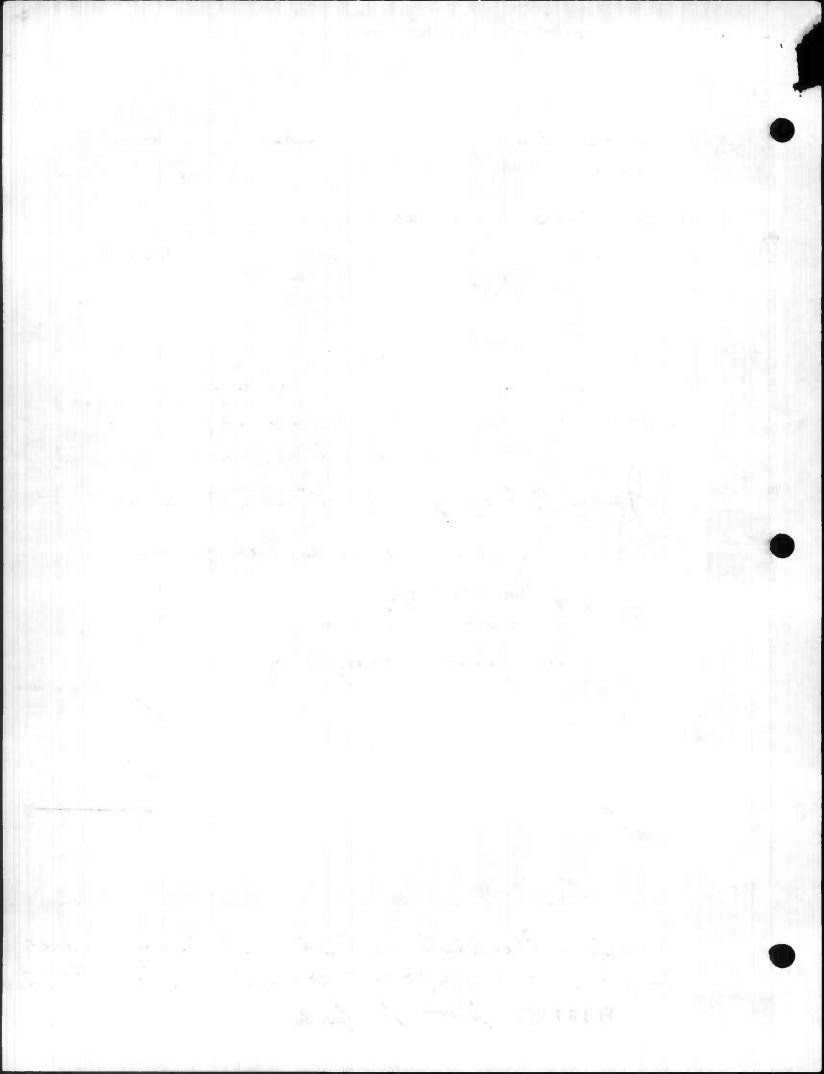
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Physician /Medical	Will	ard	Por	ter	Januar	y 28 2	2000	4:41 AM				
Examiner	4a Facility Name (# not institution, give				or Location of Deat	h 4c. County	of Death					
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Funeral Director	219 12 2009	7. Age (In yrs. 74	last birthdey) Yrs.	Months Devs Hours Min (Month Dev. Year) Country								
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of ter death with the Menylan or Nems 23e or 28e-f show cites must be notified at Funeral Director	10e. Street and Number 2523 Flagmarsh Rd.			10f. Zip Code 2177	1		10g. Citizen of United					
		12. Wes Decedent Ever in U. Armed Forces? 10€27es 2□No 194 If Yes, Give Yeer or Detes: 1946	3	Ves Decedent of I Yes, specify Cub		7 (Specify Yes or No uerto Rican, etc.)	Specif	ca · America ck, White, e	etc.			
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re, Maryland 212: s 1 and 2 should be filled within Fleath and Mental Hygiene. frem 27 is marked other than other traumatic avent, the M. To Be Comp	17. Father's Name (First, Middle, Last)		18. Mother's Neme (First, Middle, Meiden Sumeme) Addie Bennett									
C 0 0 0 0	19a. Informent's Neme/Relationship (T) Hilda R. Porter - N	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2523 Flagmarsh Rd. Mount Airy, MD 21771										
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Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once.	21. Signeture of Funeral Source Land	1//	22. Name end Address of Facility Burrier-Queen Funeral Directors, P.A.									
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To the within To the comp	29b. Signature and title of certifies	and mo		29c. Licen	31761		29d. Date sign	8/2	000			
	30. Name and address of person who con	NOR MA 50	I W. Se	SNENTH	F., 1	ereder.						
State Registrar	31. Date filed (Month, Dey, Year) FEB 0 1	2000 Pagistrar's Signa	ature	6. 1.								
DHMH 16 Rev 6/95				190	-462/							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Items 4a, 4b, & 26 Per Phy., 1/27/00, Carroll County, wjl Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Desth **Physician** Dey 17 3:02 PM 2000 Patrick Michael Propst Jan. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Carroll County 6651 Woodbine Road Woodbine Westminster Carroll General Hospital 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 6 Sex Birthplece (Stata or Foraign Country) **Funeral** Deys 1 ☑ M 2 ☐ F 58 Yrs. 219-38-3380 **Director** June 24, 1941 Maryland Usuel Rasidence of Decedent the Maryland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health end Mental Hygiena. Important: If item 27 is merked other than "natural", or items 23a or 28s-f ahov any injury or other traumatic event, the Medical Examines must be notified as 1 ☐ Yas 2 ☑ No Maryland Carrol1 Woodbine Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6651 Woodbine Road 21797 United States Funeral 14. Race - Amarican Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Roadway 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Robert Edward Propst Mary Gladys Kernan 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Barbara Ann Propst Wife 6651 Woodbine Road Woodbine, MD 21797 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 1/20/2000 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation, Inc. Hampstead, MD 21. Signature d' Funerel Service Licensee 22. Neme end Address of Fecility Burrier-Queen Funeral Directors, P.A. anne 1212 W. Old Liberty Road Winfield, MD 21784 nter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, r heart feiture. List only one cause on each line. Approximete Intervel Between Onsaf and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Examiner physician and s the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest that the death certificate be exec edicai 98 Physician/M USB signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings eveileble prior to Completed 24e. Wes en eutopsy performed? completion of causa of deeth? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ NO certificate Attending Physician: funeral director. 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 10 1 Yes 2 Vo 1 ☐ Inpatient 2 X ER/Outpetient 3 ☐ DOA After this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Hospital or Attending
 24 hours after death.
 Funeral Director: After 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a, Certifier To the Hosp within 24 hou To the Fune completely fil (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signetura and title of certifier 29c. License number 30. Name and address of person was completed cause of death (Item 23e) (Type, Print) MARYLAND 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State FEB 0 1 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Dey Carl Eugene Price February 1,2000 3:15PM 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 4615 Clymer Place Marbury Charles If Under 24 Hrs. 8. Date of Birth 9. Birthplece (State or Foreign Country)

Hours Min September 29, 1952 Mary 1 and 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthdey) Months 1 X M 2□ F Deys 217-60-7400 47 Yrs. Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Charles Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4615 Clymer Place 20658 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Service Director Car Dealership 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Carl Eugene Price I Ann Goulette 19a, Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Virginia Lee Price Wife P.O. Box 437, Marbury, Md. 20658 20b. Pleca of Disposition (Name of camefery, cremefory or other plane bruary 5, 20e. Method of Disposition 20c. Location - City or Town, Stete 2000 1X Buriel 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signeture of Funerel Service Licensee 22 Name and Address of Facility
Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. M00668 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heat failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final Small Bowel Cancer with Metatasis disease or condition resulting in death) Due to (or es a consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ONLINKnown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes XXNo 1 □Yes 2 □ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours effar. Department of Health and Mental Hygiene. Important: If Nem 27 Is marked other than "natural, or item any Injury or other treumstic event, the Medical Exercised

altimore, Maryland 21215-0020

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burial-tran pue physician s the burial 88 use signed by peen page 2 certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Division of Vital Records,

Examiner Physician/Medical þ Completed Be 2 Certification:

4 Homicide

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

26. Place of Deeth (Check only one)

February 2,2000

25. Wes case referred to medical exeminer? Other: 4 Nursing Home SAResidenca 8 Other (Specify) 1□ Yes 2□ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

28e. Dete of Injury (Month, Dey Year) Manner of Deeth 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29a. Certifier

XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

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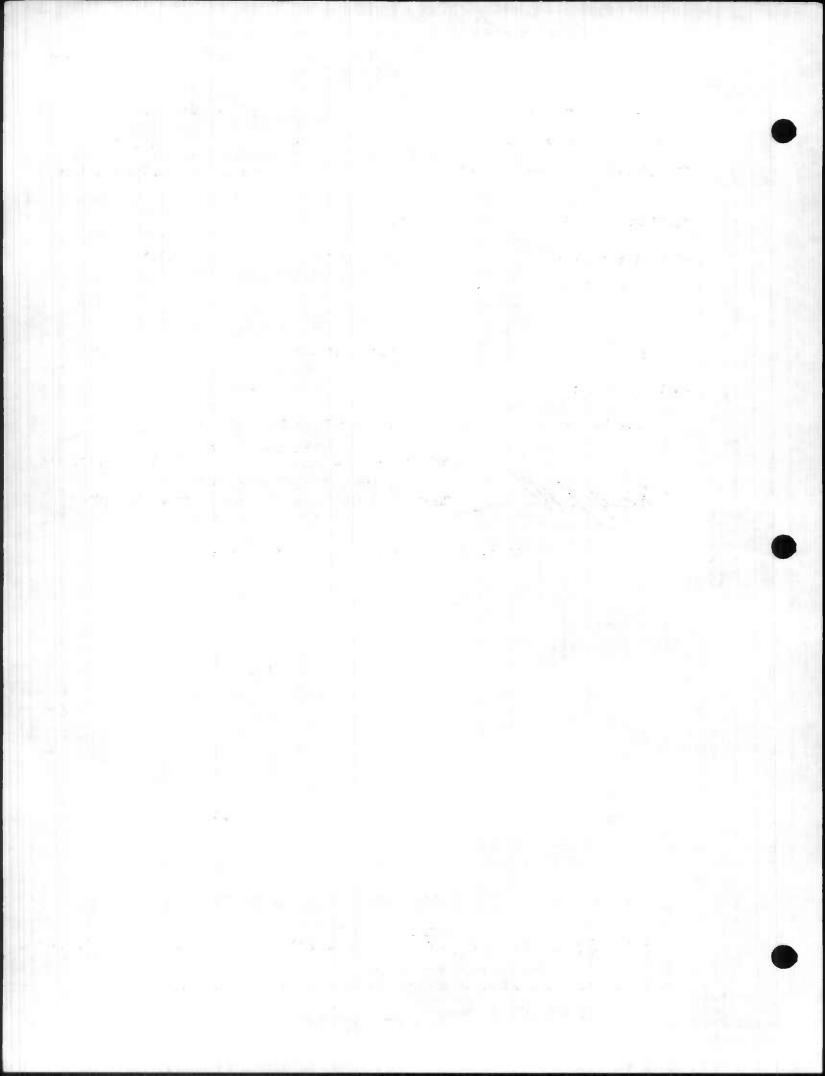
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 31. Date filed (Month, Day, Yeer) FEB 0 4 2000

State Registrar

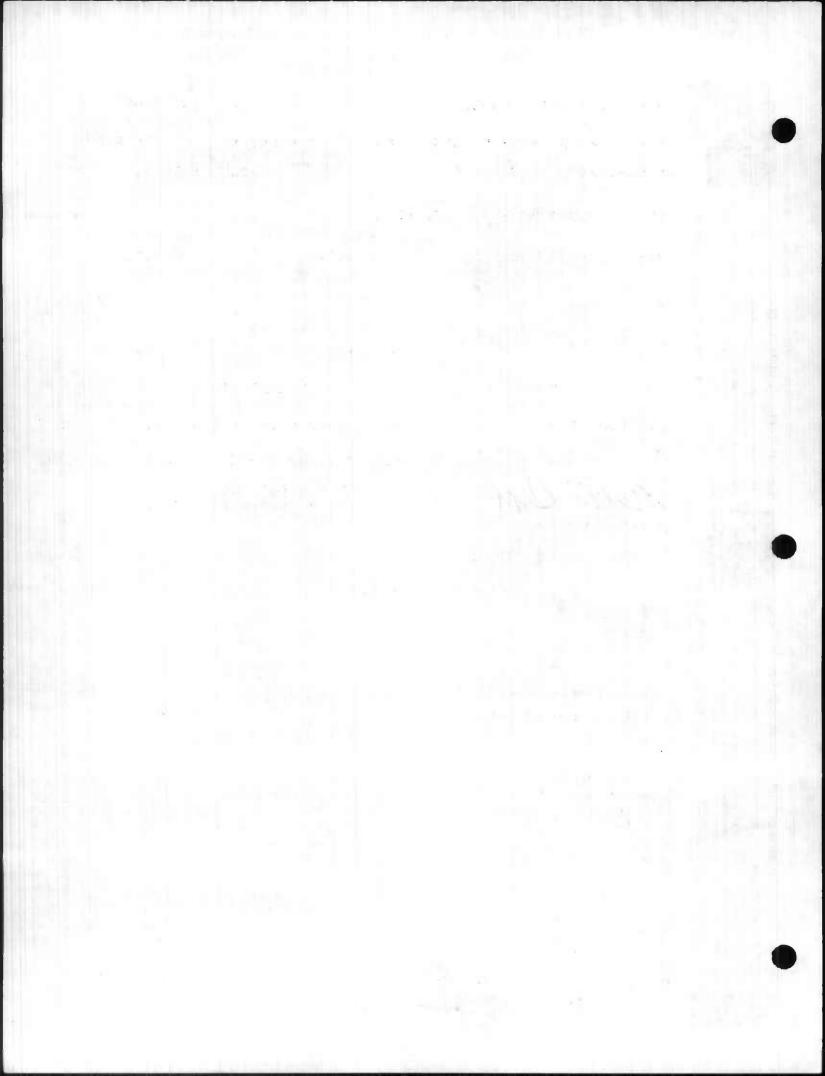
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32. Registrar's Signature



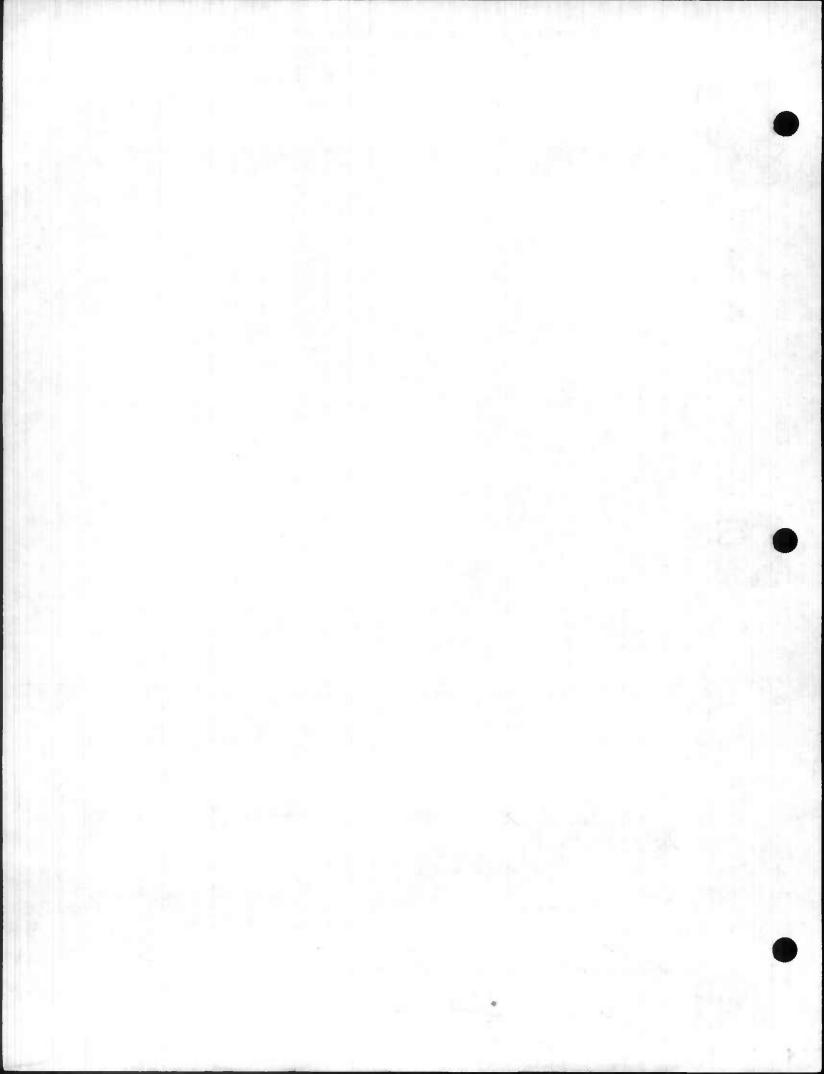
State of Maryland / Department of Health and Mental Hygiene 1 1 1581

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State of Maryland / Department of Health and Mental Hygiene 00 04581

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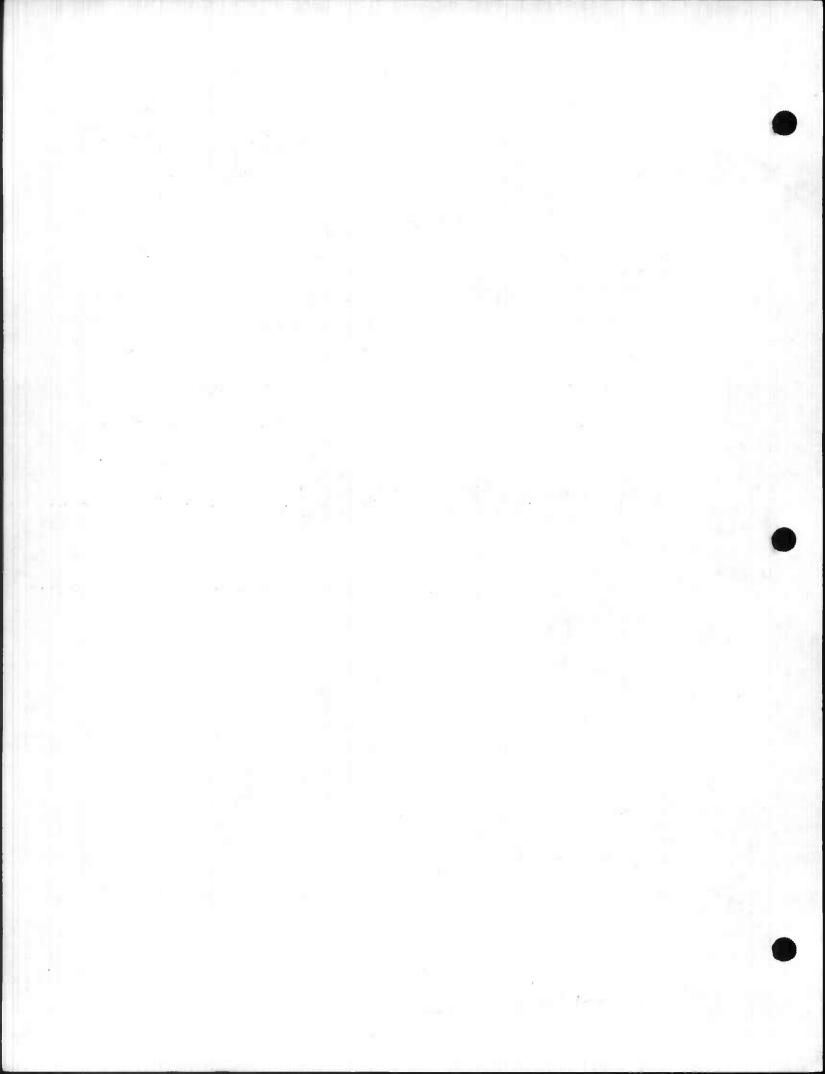
State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth Month 3. Time of Death January 25, 2000 **Physician** Mildred Poole 9:57 AM /Medical 4e Facility Neme (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2⊠ F Yes. 220-40-4262 84 Director June 4, 1915 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Damascus 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 25504 Woodfield Road 20872 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 11 Maritel Stetus filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White py 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementsry/Secondary (0-12) College (1-4or 5+) Homemaker Own home . Pages 1 and 2 should be filed w ment of Heelth end Mental Hygien sant: If Itam 27 is marked other th lury or other traumatic event, the 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Adolphus F. Fox Lillie Crum 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Ronald E. Poole - Son 25504 Woodfield Road, Damascus, Maryland 20872 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, Ststa 1 Buriaf 2 □ Cremation 3 □ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Prospect Methodist Cemetery 1/29/2000 Mount Airy, Md. 21. Signeture of Funerel Service Licensee 22. Neme and Address of Facility Olin L. Molesworth P.A., Funeral Home olasu 26401 Ridge Road, Damascus, Maryland 20872-0117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Finel diseasa or condition resulting in death) Septic Examiner Physician/Medical Examiner Due to (or as a consequence of): physician and the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated 68760 that initieted events resulting in death) Last Due to (or as a consequence of): Box Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown erebro Vascular acceden Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? Affer Division or Attending Netural 5 Pending investigation Injury after death.
Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in edicai 29e. Certifier Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier my January 26, 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Rockwille Mo BLVD Sute 340 A. MENDHIRATTA 2401 Research 31. Date filed (Month, D. A.) 2 8 2000 Registrate Signatura State

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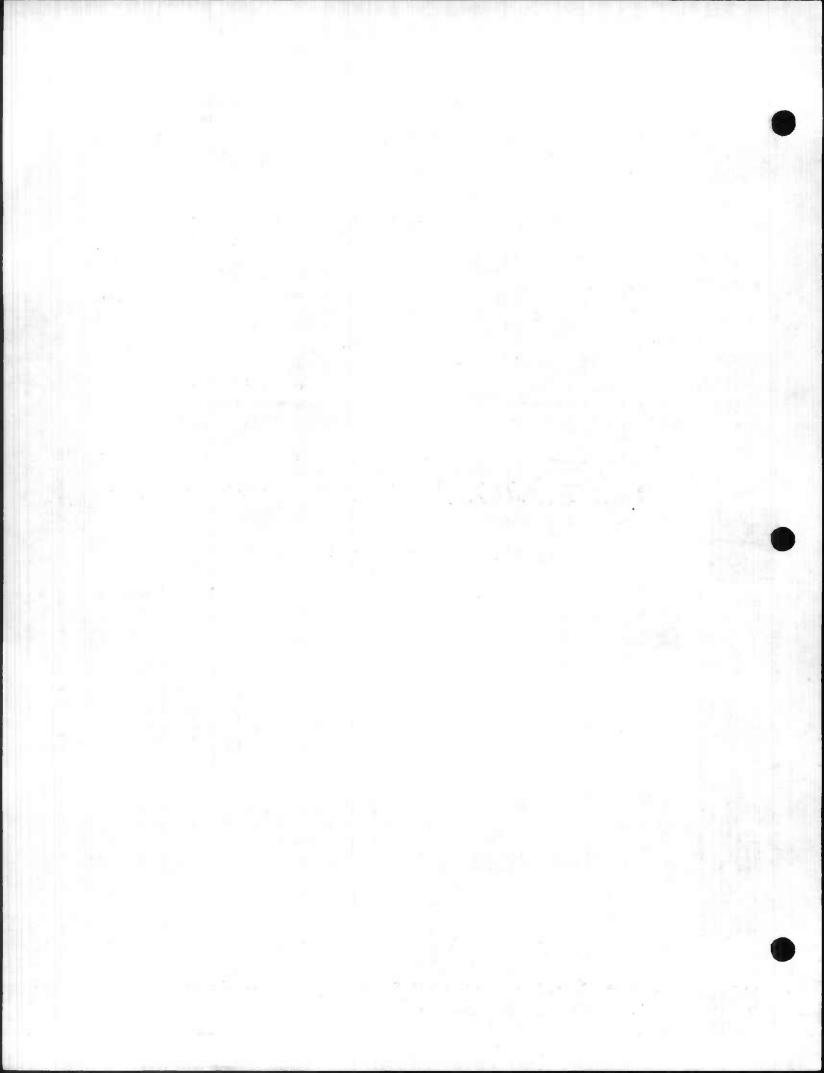


State of Maryland / Department of Health and Mental Hygiene 0

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72 hours after death with natural, or herns 23s of fical Examiner must b	by Funeral	11. Meritel Stetus 1 □ Never Merried 2 ☼ Merried 3 □ Widowed 4 □ Divorced	Vas Decedent of H Yes, specify Cubi ☐ Yes 2 No	Ispanic Ongi In, Mexican, Specify:	n? (Specify Yes Puerto Rican, et	or No- c.)		e - America ck, White, e							
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CONL	-	Martha Gay Payne 20a. Method of Disposition	- Wife	20b. Plac	e of Dispos	lamar St		#4, Ga:			, Mar	The second secon			
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Department of Heal may Injury or other other.		Green Cove Baptist Cemetery 1/25/00 Green Cove, Virgi 21. Signature of Funes Service Licensee 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home													
Physician /Medical		26401 Ridge Road, Damascus, Maryland 20872-01											17		
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the disease, and the death disease that caused the death disease that disease the disease that caused the death disease that disease the death disease that disease the di													
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State of Maryland / Department of Health and Mental Hygiene 04584 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death January 29, 2000 **Physician** Frank John Puglise 8:15 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) March 2, 1913 Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 577-01-8866 1**∑** M 2□ F 86 Vre Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yas 2 No Frederick Frederick Maryland Directo 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A. 1001 Carroll Parkway, Apt. 115 238 Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 21215-0020 b 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Transportation Specialist US Government altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 8 Pages 1 and 2 should be nent of Health and Mental **Puglise** Frances Venuto Guiseppe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1001 Carroll Parkway, Apt. 115, Frederick, Mt. 21701 Mrs. Mildred G. Puglise, wife 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory, Jan. 31, 2000 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Lickness MO0255 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one dause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 5 days diseasa or condition resulting in death) neumanic Examiner Physician/Medical Examiner myocare The lew requires that the death certificate be executed the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Records, P.O. Box 68760, Due to (or as a consequence of) 080 08 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown A 5.8 24b. Were autopsy findings evailable prior to Completed 24a. Wes an autopsy performed? completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Division of Vital ial or Attending Physicien: The sher death.

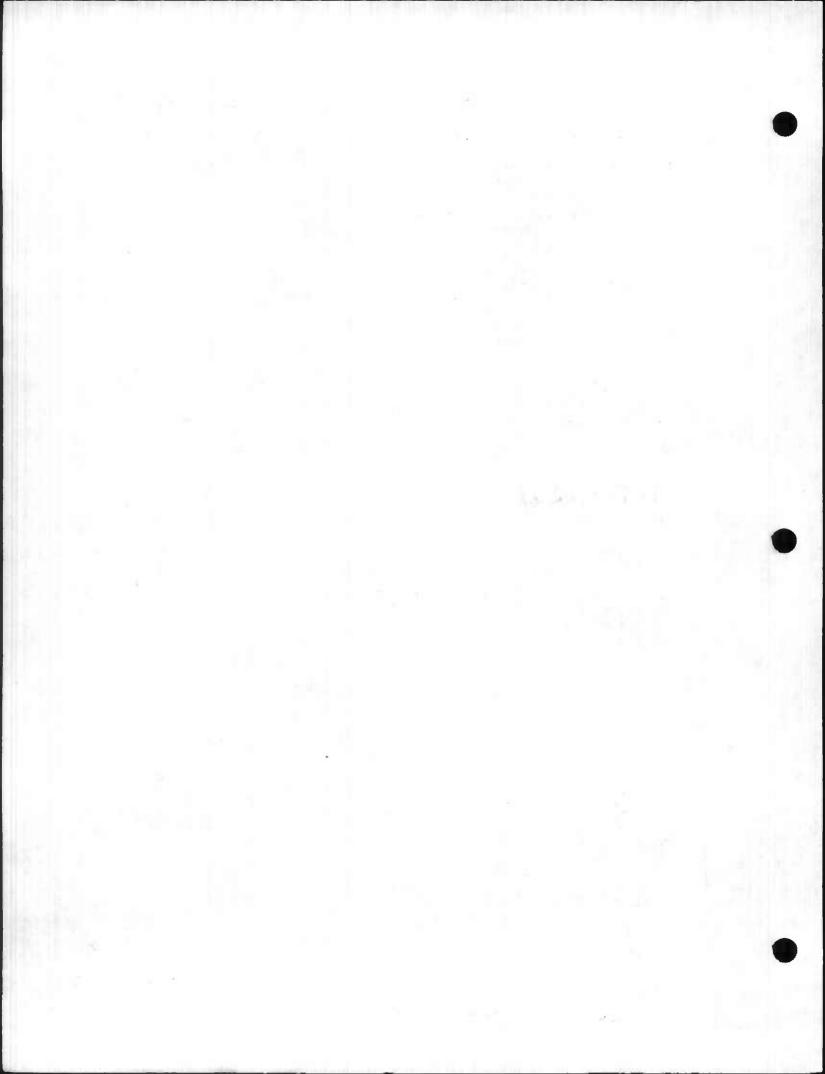
Si Director: After this centilicated in by the funeral director, pi 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 24 hours efter de e Funeral Directo pletely filled in by th 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certific To the Hosp within 24 hou To the Fune completely fil Medical 29b. Signatu and tale of certifier 29d. Data signed (Month, Day, Year) 29c License number D51643 January 31, 2000 - mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiren N. Shah, M.D., 170 Thomas Johnson Drive, Suite 100, Frederick, Md. 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene 04585 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** 4b. City, Town, or Location of Death J 4c. County of Death Phoebus 1731 Virginia 2000 /Medical 4a Facility Nama (If not institution, give street and number) **Examiner** PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Deys Director 578-22-4508 05/30/1925 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 25a-f show must be notified at 1 Yes 2 □ No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? b Berns 23a 21804 USA 820 South Schumaker Drive Apt. 201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No "natural", or Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Ilem 27 is marked of Mitchell Lewis Minnie Beauchamp 19e. Informent's Name/Raietlonship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) J.M. "Buck" Phoebus/Husband 820 S. Schumaker Dr., Salisbury, Md. 21804 altimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20s. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriai 2 □ Cremetion 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) Grace Episcopal Cemetery 1/30/2000 Mt. Vernon, Md. 22. Name and Address of Facility
Hinman Funeral Home 2). Signeture of Funerel Service Licenses 1 px ac M00295 11673 Somerset Ave., Princess Anne, Md. 21853 23e Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one causa on aech lina. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Rudian disease or condition resulting in deeth) Examiner arten Dwnam and Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Last sequence of): Due to (or as a c Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Structive disease þ 24b. Ware sutopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attanding Physician: Be 25. Was case rafarred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a Deta of Injury (Month, Day Year) To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel
2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) end manner steted. 29e. Certifier edicai (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number a. Wernich M.D. 15384 nw 28, 2000 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) WENRICH 100 POWER STREET SALISBURY

State Registrar

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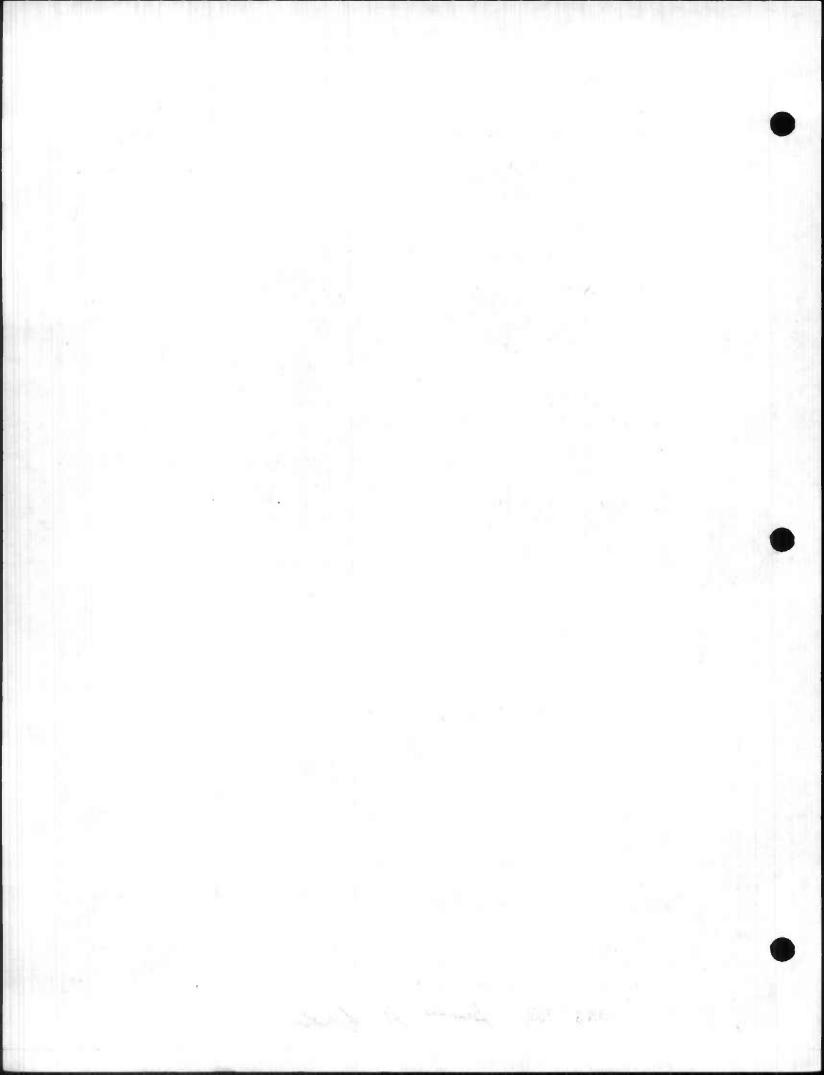
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32. Registrar's Signeture

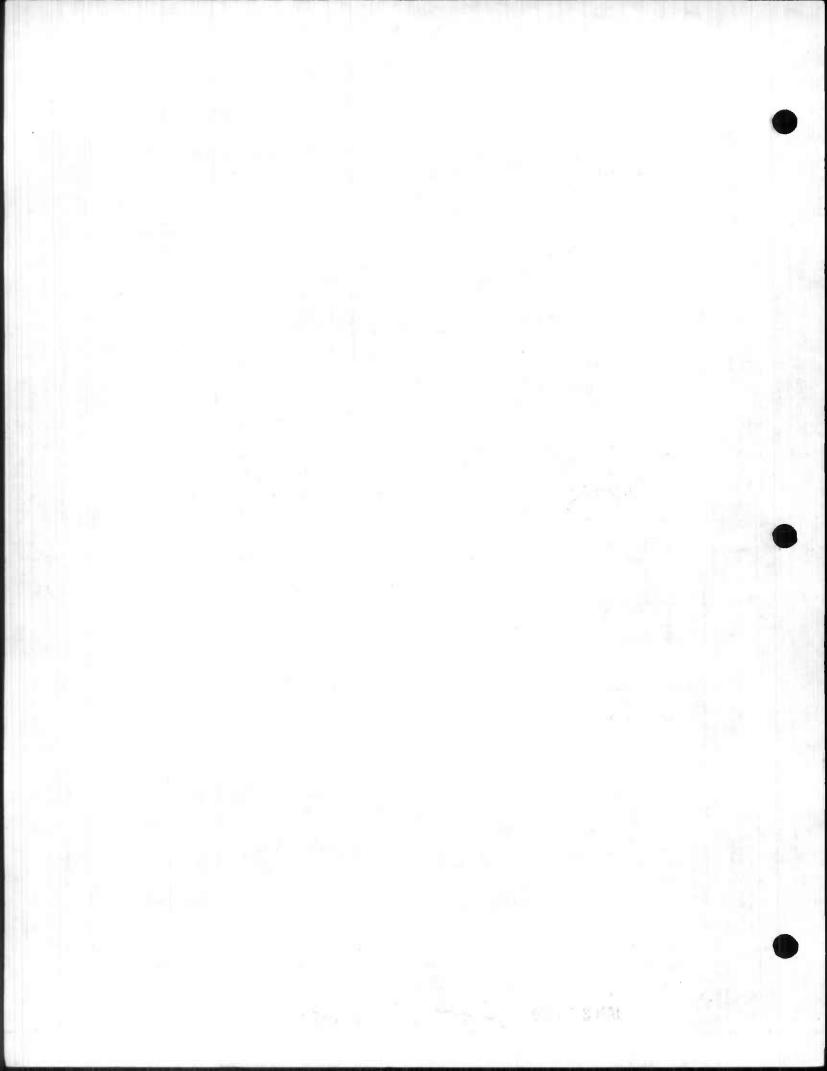
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician ISOLENE ELKINS RHOTEN 28, 2000 21:15 JAN. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Months 214-20-5786 Director 1/19/1926 KENTUCKY Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits MD. CARROLL WESTMINSTER 1 Yes 2 No Directo 288-1 10e. Street and Number 10f Zip Code 10a. Citizen of What Country? 'natural', or flems 23s or 30 LOCUST ST., APT. 204 21157 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 11 SEAMSTRESS MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nd 2 should be filth and Mental 9 27 is marked of r traumatic ever Be permit. Pages 1 and 2 should be Deportment of Health and Mental Important: if Item 27 is marked eny Injury or other traumatic events. FURBAN ELKINS ELLA LOVEJOY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN SCOTT -SISTER 401 BARNES AVE., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/00 METRO CREMATORY BALTIMORE, MD. 21. Signature of Famoral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Effit only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Hypoxemia Secondary to Respiratory failure Examiner Due to (or as a consequence of): Examiner Myocardial physician and the burlat-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of): Box 68760. Rena Physician/Medical P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown obstructive signed t Pulmonan disease Records, Py 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 200 No 1 □ Yes 2 □ No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this cardific complately filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitat: 2 ER/Outpatient 3 DOA 1 Yes ZNO Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Dalatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. D D 52479 January, 28, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LiSA K-, M. D. at Carroll County General AVENUE 200 memorial West minster. HOSPITOI. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JAN 3 1** Registrar 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month **Physician** Roseanna 0215 Can Lany 21, 2000 postion of Death 4c. County of Death /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER 05e anna Rigsby SSH 410957-099 Baltimore, Maryland 21215-0020 SALISBURY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 👿 F 70 -30-150 1419 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits them 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Medical Examinar must be notined at Pocomoke 1 Yes 2 No **Funeral Director** Worce 10g. Citizen of What Country? 10e. Street and Number 10f Zio Code 8 1.S.A. Bonneville 12. Was Decedent Evar in U,S. Armed Forces? Race - American Indien, Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yas 2 No If Yes, Give Year or Detes: 12 Never Married 2 Married 1□ Yes 20 No Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 3 00 OUK 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be 19a. Informant's Neme/Relationship (Type, Print) Boatrice +Fank 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Alcondria permit. Pages 1 and 2 Department of Health a Important: If them 27 is any injury or other tra 20b. Plece of Disposition (Name of camatery, cremetory or other plece) 22307 Rd. trecting daughter Va 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata Mt. Siva Baptist Cenetary
22. Namb end Address of Fecility
Bennie Snith 4 □ Donetion 5 □ Othar (Specify) Poranoke Ma 21. Signature of Funeral Successions and Funeral Honc 23a. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory shock, or heart failure. List only one ceuse on each line. City ind, Physician Zweek /Medical Immediata Cause (Final actual diseese or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate causa. Enter Undarlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1. Yea 2□ No 3 Probably 4 Unknown Pulnona Division of Vital Records. Completed by 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Attending Physicien: funeral director, 25. Was casa refarred to medical examiner? Be 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Invastigation 1 Natural 2 Accident within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 8 Hospital 29a. Certifier Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

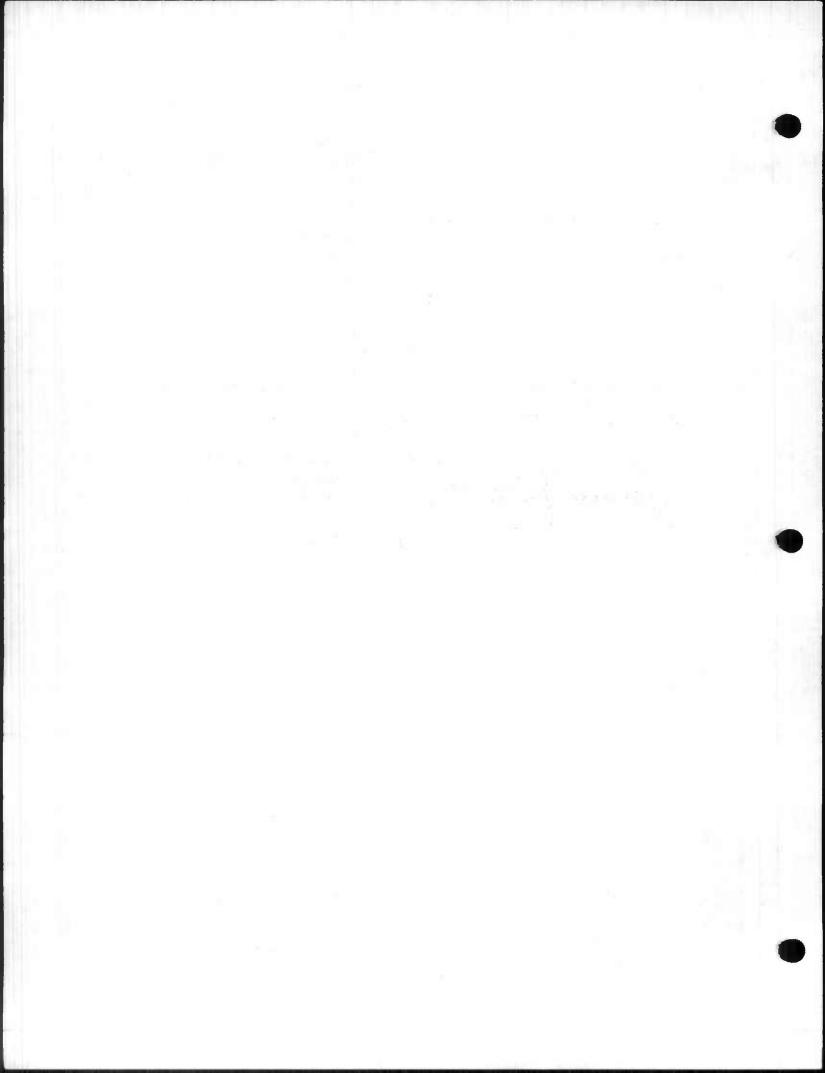
— Magical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the miner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 4 29b. Signeture and 1110 29d. Date signed (Mghth, Day, Year) 29c. License number conf 00 322 30. Name and address of person who completed cause of death (Item 23a) (Type, Priot) SALIS BURY LAY TOZ KODNEL 31. Date filed (Month, Dey, Year) 32: Registrer's Signeture State 3 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month JAMES SAMUEL ROBINSON, SR. 25,2000 3:59PM JANUARY /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 2360 ANDREWS ROAD **CRAPO** DORCHESTER | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | SEPT 22, 1929 5. Sociel Security Number Birthpiece (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F 213-22-9637 Yrs. Director 70 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND DORCHESTER **CRAPO** 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? mast be r 2360 ANDREWS ROAD 21626 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 (X)Yes 2 (☐ No 1951— If Yes, Give Yeer or Detes: 1953 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Be Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WATERMAN SEAFOOD L. Pages 1 and 2 should be filed w riment of Health and Mantal Hygio riant: If them 27 is marked other t slury or other traumatic event, the 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) FREELAND MONROE ROBINSON HAZEL REBECCA MILLS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health is Important: If item 27 is any injury or other trau KAY F. ROBINSON/WIFE 2360 ANDREWS ROAD, CRAPO, MD 21626 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5) Other (Specify) MD. VET. CEM.EASTERNSHORE1/31/00 BEULAH, MARYLAND feral Service Little 22 Name and Address of Fecility ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD lications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each line. Approximate Intervai Between Onset end Deeth Physician ling Caneer. metamatee mmediate Cause (Final months disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): P.O. Box 68760, requires that the death certificate be that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2□ No 3□ Probably 4□ Unknown Division of Vital Records, by Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? certificate has 1 Yes 3€ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Massidence 6 Other (Specify) ٥ Z No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 25.0 27. Manner of Death Certification: 28d. Describe how injury occurred Affec Injury at Work? Natural 2□ Accident 5 Pending investigation Attending I or Attending after death, Director: At 1 Yes 2 No € Could not be 3 C] Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Dey, Year) D50987 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) sweet lambwdge mo21613 NAWAZ Ano 300 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 29 00 10 40 AM ROBERT HARLAN ROBERTSON JR. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Worcester Atlantic General Hospital Berlin Birthplaca (State or Foreign Country) If Undar 1 Yaar 5. Social Security Number If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) 6. Sax Days Min. 1 M 2 □ F Months Hours 84 7/12/15 MD 204-05-6077 Usuai Residence of Decedan 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County MD Worcester 1 ¥ Yes 2 □ No Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 Meadow St. Apt. 214 21811 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1.2XYes 2 □ No If Yes, Give WW I 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxicen, Puarto Ricen, atc.) 11 Maritai Status 1 Never Married 2X Married WW11 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Eiamentary/Secondary (0-12) College (1-4or 5+) President/General Manager Plumbing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Harlan Robertson, Sr. Gertrude Kerns 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 613 Market St. Pocomoke City, MD 21851 Martha Jackson/ Daughter 20b. Place of Disposition (Neme of cemetery, crematory or other place emetery 20a. Mathod of Disposition 20c. Location - City or Town, State 1XXX uriai 2 ☐ Cramation 3 ☐ Ramoval from State Pitts Creek Presbyterian 2/1/00 Pocomoke City, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 23a. Part. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haar failura. List only one caused line. Approximate Interval Between Onset and Death Alzheiners Immediate Cause (Final 2 48213 disaase or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? bleed ing 1 Yes 2 No 3 Probably 4 Unknown gestrom testerel 24b. Were autopsy findings available prior to complation of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 (4) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 281. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

physician and s the burial-transit as t usa signed by the a d be detached f certificate has t Physicisn: After this or Attending death. after deati Director: n 24 hours after des ve Funeral Director pletely filled in by th Hospital To the Hosp within 24 hor To the Fune completely fi

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Pages 1 and 2 should be filed within 72 hours after death with intent theath and Mental typiene.

Int. If ham 27 is marked other than "natural", or itema 23a or intro other traumide event, the Medical Experies matter.

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Examiner

Physician/Medical Examiner

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29a. Certifier

(Check only one)

/Medical

Baltimore, Maryland 21215-0020

Director

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Registrar

31. Data filed (Month, Dey, Year)

29b. Signature and title of certifier

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) 973 32. Registrar's Signatura

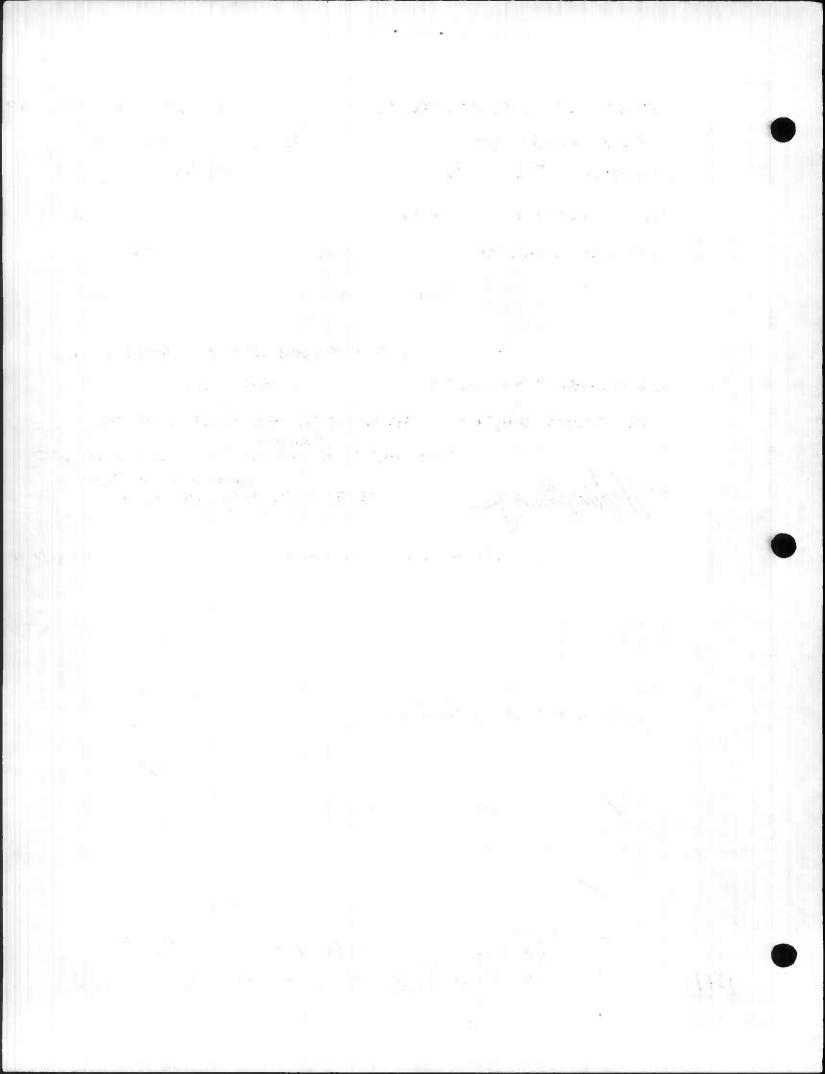
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1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, date and placa, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04590 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vest KEDMAN 10:17 Am ELEN) 2000 Jan vary 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of De th 4c. County of Death GREENPOINT East New Market 3632 Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. 9. Birthplace (State or Foreign Country)
PENNSYLVANIA 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 ☐ M 2 K F MARCH Yrs 175-24-0129 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND DORCHESTER EAST NEW MARKET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3632 GREEN POINT ROAD 21631 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritai Status 1 ☐ Yes 2 K No if Yes, Give Yeer or Dates: 1 Never Married 2 Married 1□Yes 2₩No Specify 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **OPERATOR** 12 TELEPHONE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) CHARLES BULINSKY ANNA WAXMUMSKY 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) CHARLES T. REDMAN/HUSBAND 3632 GREEN POINT ROAD, EAST NEW MARKET, MD 21631 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlal 2 X Cremation 3 ☐ Removal from State 4 Donation ↑6 Other (Specify) CAMBRIDGE CREMATORY 1/26/00 CAMBRIDGE, MARYLAND 22. Name end Address of Facility ZELLER FUNERAL HOME, P. O. BOX 207, 21. Signature of Funerei Service/L UNIX 106 MAIN STREET, EAST NEW MARKET, MD 21631 Punt Enter the diseasa, or heart failure. Lis complications the caused tha daath. Do not entar the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Deeth Immediata Cause (Final disease or condition resulting in death) CEREBRO VASCULAR A-CLIDENT ereard uascular Dua to (or as a consequence of) Due to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 15 No 1 ☐ Yas 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical axaminer? 26. Placa of Death (Check only ona) Hospital: 1 | Inpatiant 1X Yas 2 No 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

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Division of Vital Records,

pernit. Pages 1 and 2 at Department of Health and Important: If them 27 is in any injury or other traum BRISE.

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "na

Examiner burial-tran physician sthe burial Physician/Medical 88 þ Completed paga 2 funaral director, Be J_o Certification:

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated avants resulting in death) Last

27. Manner of Death

1 MNatural

2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifie

Other: 4 ☐ Nursing Home 5 📈 Residenca 6 ☐ Othar (Specify) 28d. Describe how injury occurred

28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and placa, and due to the cause(s) and manner as stated.

29b. Signeture and title of cartifie

5 Pending investigation

6 Could not be datarminad

29c. License number

2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) January 24, 2000

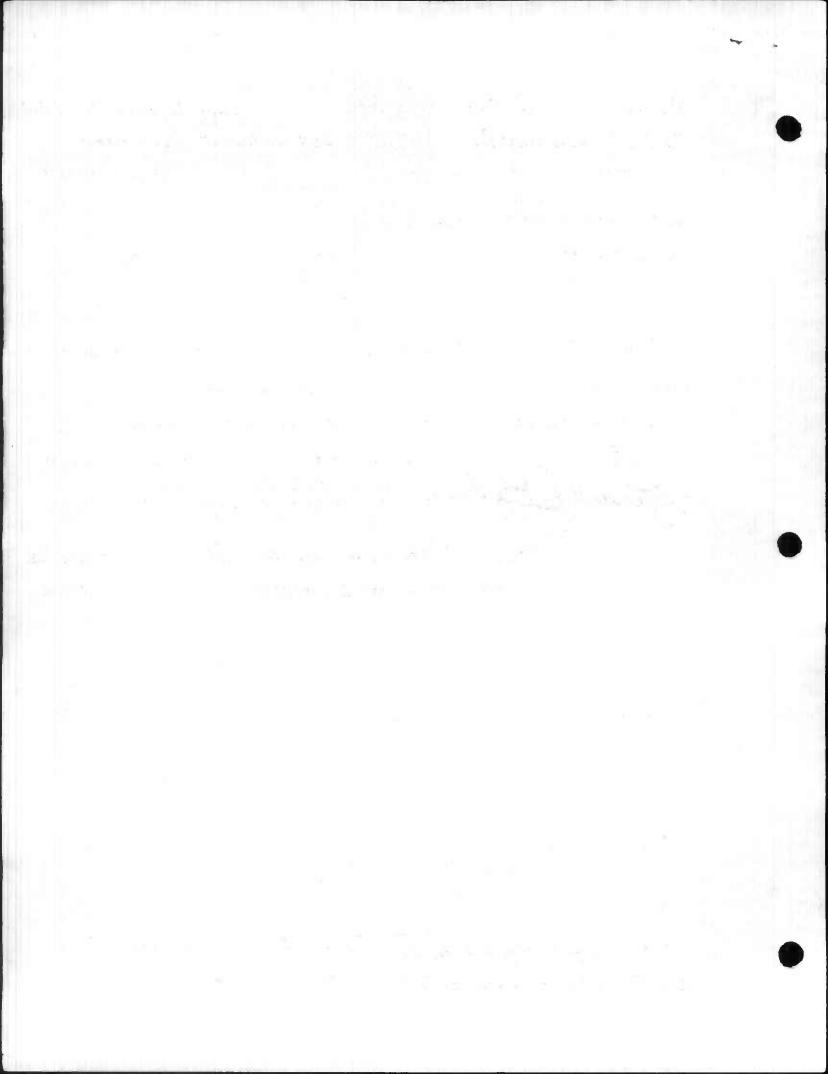
ot daath (Itam 23a) (Type, Print) DENTON MD 21629 .E. JENSEN M.D. P.O.BOX 690,

State Registrar

edical

2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year **Physician** 1600 HENRY M. ROBBINS Tanuary 30, 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year 8. Date of Birth (Month, Day, Year) 6-18-1926 Birthplace (State or Foreign Country)
 VIRGINIA 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months 73 230-18-0640 Director Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f show must be notified at 1 Yes 2 No Director DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? RD#2 BOX 162 19975 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. pernit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or the any injury or other treumatic event, are Medical Examine page. 1 Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SHIPPING CLERK POULTRY PLANT 17. Father's Neme /First Middle | ast) 18. Mother's Name (First, Middle, Maiden Sumeme) Be HENRY ROBBINS SALLIE ISDELL 19s. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD#2 BOX 162, SELBYVILLE, DELAWARE. 19975 HILDA M. ROBBINS/WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 □ Cremetion 3 □ Removel from Stete 5 Other (Specify) 2-3-2000 4 Denetion MILLSBORO CEMETERY MILLSBORO, DELAWARE nature of Puneral 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST., FRANKFORD, DELAWARE. 19945 , or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, List only one cause on each line. Part Enlar the shock, or heart Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final world disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of): signed by the at d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes X No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 28 No 1 Yes 2 No certificate Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27: Maprier of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Neturel 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertiling 1-31-00 26278 Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) 145E. 31. Dete filed (Month, Day, Year) 32. Begistrer's Signeture State

DHMH 16 Rev 6/95

Registrar

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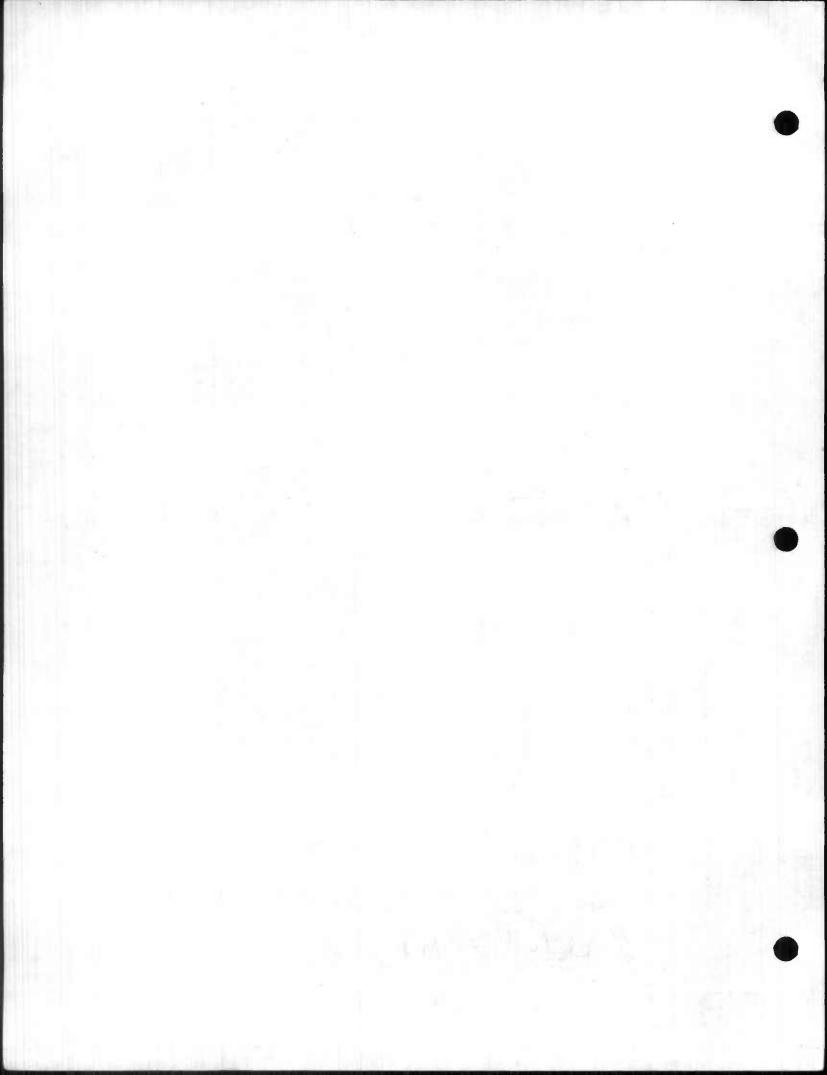
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State of Maryland / Department of Health and Menta	I Hygiene ()	0459
Certificate of Death	Reg. No.	

				Certificat	e of	Death		Re	eg. No.		
	1. Decedent's Name (First, Middle, L	ast)					2	. Date of Death		Year	3. Time of Death
Physician /Medical	The Market Comment	Horace	L. Rabb	itt				January			12:30 AM
Examiner	4e Facility Neme (If not institution, g							ition of Death	4c. County	of Death	
	Suburban Hospit	:al				Beth	esda		Mont	gomer	У
Funeral Director	5. Social Security Number 6. 213-44-6250 Usual Residence of Decedent	100M 200 E	(In yrs. last birtl	Months	1 Year Deys	If Under Hours	Min	Date of Birth (Month, Day, (ay 29,	Year) 1928	Coun	piace (State or Foreign stry) Land
And And	10a. Stete 10b. County		10c. City, Town	or Location						1	Od. Inside City Limits
Maryla a-f show filed at	Maryland Montgo	mery	Bet	hesda							1 ☐ Yas 2 ☑ No
death with the Maryland me 23e or 28a-f show creat be notified at neral Director	10e. Street and Number			10f. Zip	Code			10	0g. Citizen of \	What Coun	ifry?
w file	5721 Grosvenor I	ane			814				United		
- F 5 5 5	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 Yes	100			ity Yes or No- can, atc.)		e - Americ ck, Whita,	
72 ho	15. Decedant's i	ducetion	16a. l	Decedent's Usu Give kind of wo	al Occuj	pation during mos	t of working		16b. Kind of B	usiness/Inc	dustry
1 21215-0 ed within 72 ho ygiene. er than 'natur t, the Medical I	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT u	se retire	d)					
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Maryland 21215-0020 It is and Mental Hygiene. This marked other than "natural; or traumatic event, the Medical Exam To Be Completed by it	77 1 7 11 1	t)					en Atv		naideri Suman	10)	
ore, Marylar s t and 2 should be them and Menta them and Menta other traumatic as	19e. Informent's Name/Relationship	(Type, Print)	19b.	Mailing Address	(Street	and Numb	er or Rural i	Route Number,	City or Town,	State, Zip	Code)
	H. Gerlad McGuire	/Trustee	10	707 Ben	tley	Lane	, Ken	singtor	n, MD 2	0895	
Baltimore, semil. Pages 1 a Separtment of the rey injury or other mice.	20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemetery	Disposition (Nai crematory or c ry's Ce	other pla			b. 5.	20c. Location -		own, Stata aryland
Baltimo permit. Page Department of Important: If any Injury or ansa.	21. Signature of Funeral Service Lice	/	100198	Robert 7557 W Bethes	A.ddre	Pumph nsin	rey F Avenu	uneral		ethes Cha	sda-Chevy se, Inc.
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/Medical Examiner	Immediate Cause (Final disease or condition	Pneumo	Pneumonia								3½ days
	rasulting in death)	Aspira	Oue to (or as a c	onsequence of):							4 days
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68760, directe be exa g physician a se the burial-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	al Pals	-							Lifelong
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Box death ce attendi	Pert II. Other eignificant conditions	contributing to death but	not resulting in	the underlying o	ause di	ven in Part	1.	23b. Did to	bacco use co	ntribute to	o the cause of death?
o. at the act of the state of t					audo g.				• 2⊠ No		bebly 4 Unknown
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requirements								24a. Was a perform		ev co	ere autopsy findings allable prior to empletion of cause death?
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f Vital I yalclan: The yalclan: The securificate director, page	25. Wes case referred to medical examiner?					26. Piace	e of Death	Check only on	(6)		
- 5 of	1 Yes 2 No	Hospital: 1 🖾 Inpatien			JA		ursing Home	5 ☐ Reside	ence 6 🗆 Oth	ner (Specif	'y)
Division o or Attending Ph stret death. Director: After thi d in by the funeral ertification: 7	27. Manner of Death 1 ②Netural 5 Pending 2 Accident Invastigati		Year) 28b. Ti	ma of jury M	28c. Inju Wo 1 □	ryaf rk?]Yes 2 □		ld. Describe ho	ow injury occur	red	
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Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completaly filled in by the fune. Medical Certification	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hyelcian: To the best of miner: On the besis of e and mannar state	xamination and	death occurred /or investigation	at the ti	me, date an opinion, dea	nd place, an oth occurred	d due to the ca at the time, da	ause(s) and mate and place,	anner as s and due to	tated. o the cause(s)
To with To the Com	29b. Signature and title of certifier	n. (/	1	29	c. Licen:	se number		2	9d. Date signe	d (Month,	Day, Year)
20	1 cph	In tra	m M.	0	D01	191			January	25,	2000
	30. Name end address of person who Ralph M. Coan, M		ulver S	**	Kens	ingto	n, Ma	ryland	20895		
State Registrar	31. Data filed (Month, Day, Year)	32. Pagistrar		1 1	ak.						

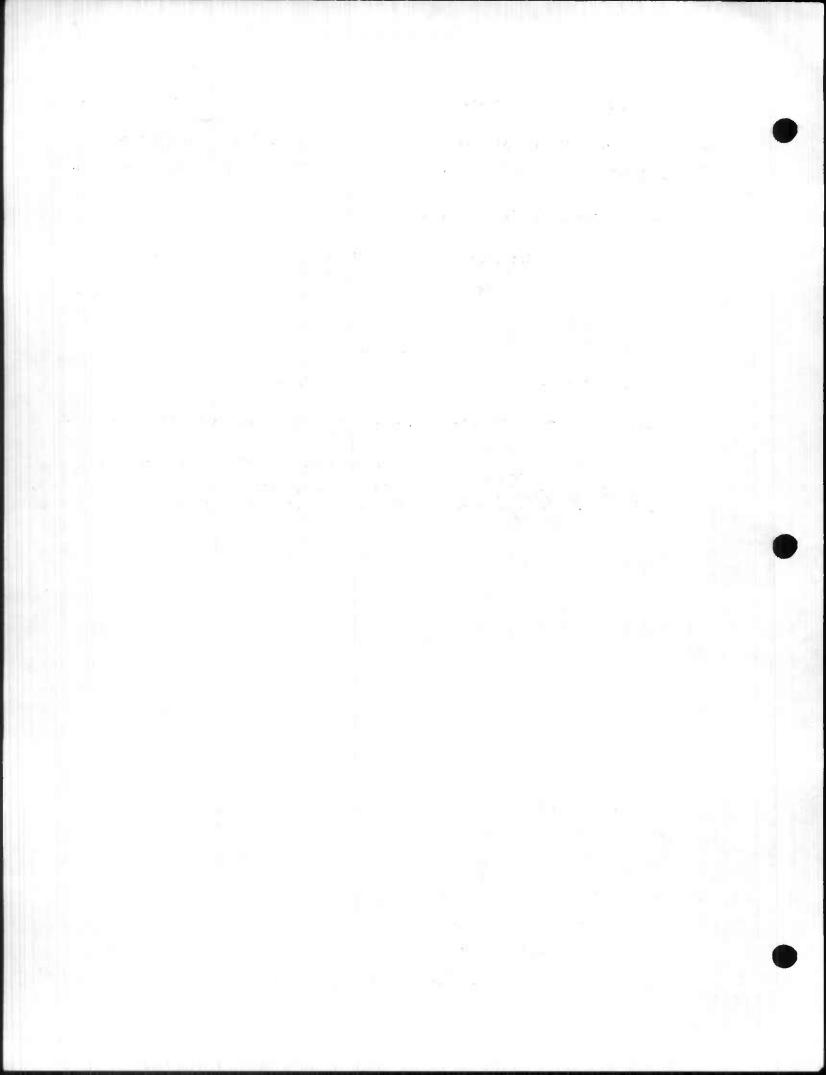


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

04593 State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elsie Gretchen Ritmiller 21,2000 12:15PM January /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Queen Anne's Oueenstown 1301 Bennett Point Road if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)
Jan. 11,1910 if Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2□F Months Days Yrs. 90 Mary land Director 215-05-4642 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inaide City Limits r 28a-f show 1 ☐ Yes 2K No Queen Anne's Queenstown MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examinar must be a U.S.A. 21658 Bennett Point Road Peges 1 and 2 should be filed within 72 hours effer death nent of Heelth end Mental Hygiene. Int: If Item 27 is marked other than "naturel", or items 23. Funeral 1301 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lizette Sichert Joseph Maser 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 1301 Bennett Point Road Queenstown, MD. 21658 Holmes / Daughter Lila I. Jan.27, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State = 5 permit. Pege Department of important: It any injury o 4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery 2000 Baltimore, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road Chester, MD. 21619 ication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne card a on each line. Part 1. Enter the disease, or complication shock, or heart failure. List only one ci Approximate interval Between Onset and Death **Physician** Myocardial Entortem /Medicai Immediate Cause (Final das disease or condition resulting in death) Examiner Due to (or as a consequenca ot) Examiner physician and s the bunal-transit The law requires that the death certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 950 signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes ANO à 24b. Were eutopsy findings aveilable prior to completion of cause of daath? should s 24a. Was an autopsy performed? Completed certificate has b 1 Yas 25 200 1 □ Yes 2 □ No Hospital or Attending Physician: '24 hours effer deeth.'
Funeral Director: After this certifica director, Be 25. Was case rafarred to madical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicida To the Hospital or within 24 hours eff To the Funeral Di completely filled in Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifi 29c. License number B. Daruh Drue Chole MD 2/6/19 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) prose Ĵ 21012 ban 31. Data filed (Month, Day, Year)
JAN 2 8 2000 32. Registrar's Signatura State aner

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year HARLENE L. RACOOSIN JANUARY 31, 2000 4:55 A.M. 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BETHESDA SUBURBAN HOSPITAL MONTGOMERY If Under 1 Year 8. Dete of Birth (Month, Day, Ye. JUNE 8, 1 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplece (State or Foreign Months Days Hours WASHINGTON, D.C 577-42-7911 68 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY CHEVY CHASE MARYLAND XX Yes 2 No 10e. Street and Number 101 Zin Code 10a, Citizen of What Country? 5600 WISCONSIN AVENUE, APT. 1001 20815 U. S. A. 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 22 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 YEARS Cotlege (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MAURICE ABRAHAM PHOEBE GOLDBERG 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ROBYN R. BERNITT - DAUGHTER 9201 POTOMAC SCHOOL DRIVE, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, cremetory or other plece) WASHINGTON HEBREW CONG. MEMORIAL PARK 1 Description 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 2/3/2000 Washington, D. C. 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter the disease, or complications that caused a deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest Due to (or as a consequence of): MOCAICINOMO Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings svaileble prior to 24a. Wes an autopsy performed? completion of cause of death? 2 No 1 Yas 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

23a or

natural, or flams

72 hours after

I Hygiene.

Department of Health and Mental Hygle Important: If Item 27 ia marked other t any injury or other traumatic event, to

Pages 1 and 2 should be nent of Health and Mental

altimore. Maryland 21215-0020

Box 68760.

1/31/00

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ACCOSIN, HARLENE

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Funeral

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To the Hospital or within 24 hours aft To the Funeral Di completely litted in

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medicel examiner? 26. Place of Deeth (Check only one) Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Netural 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the cause(s) end manner as stated.

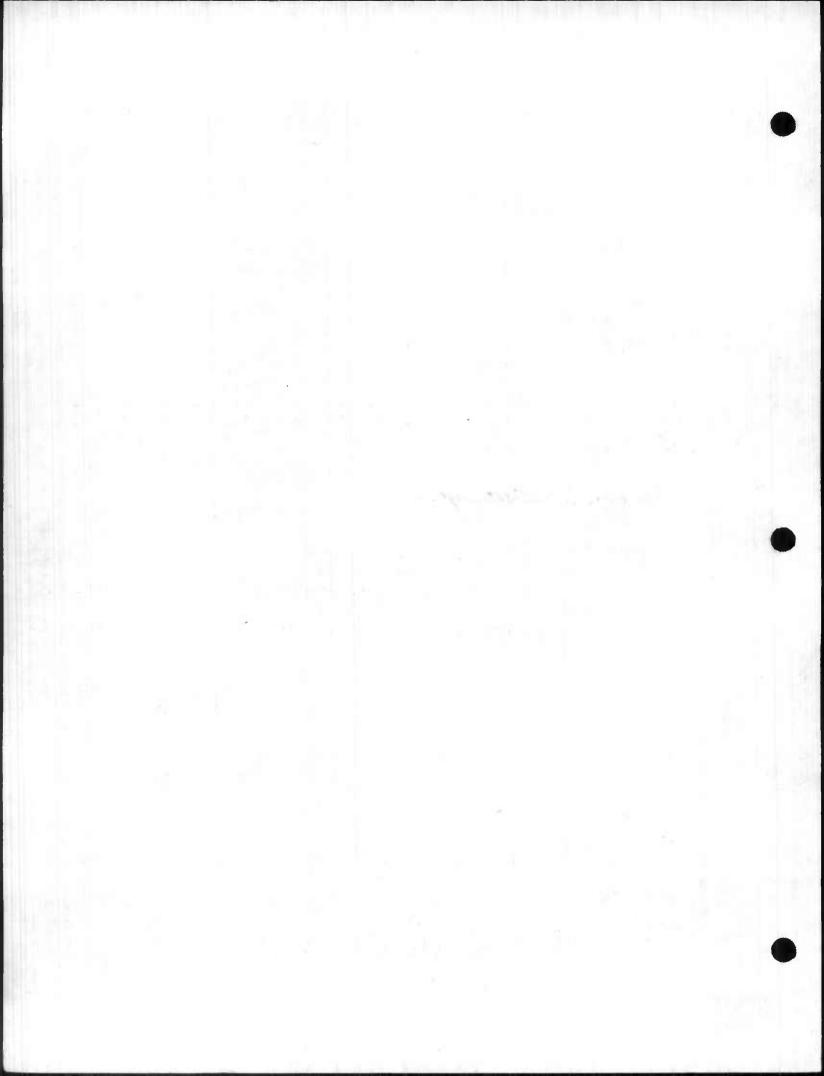
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29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year)

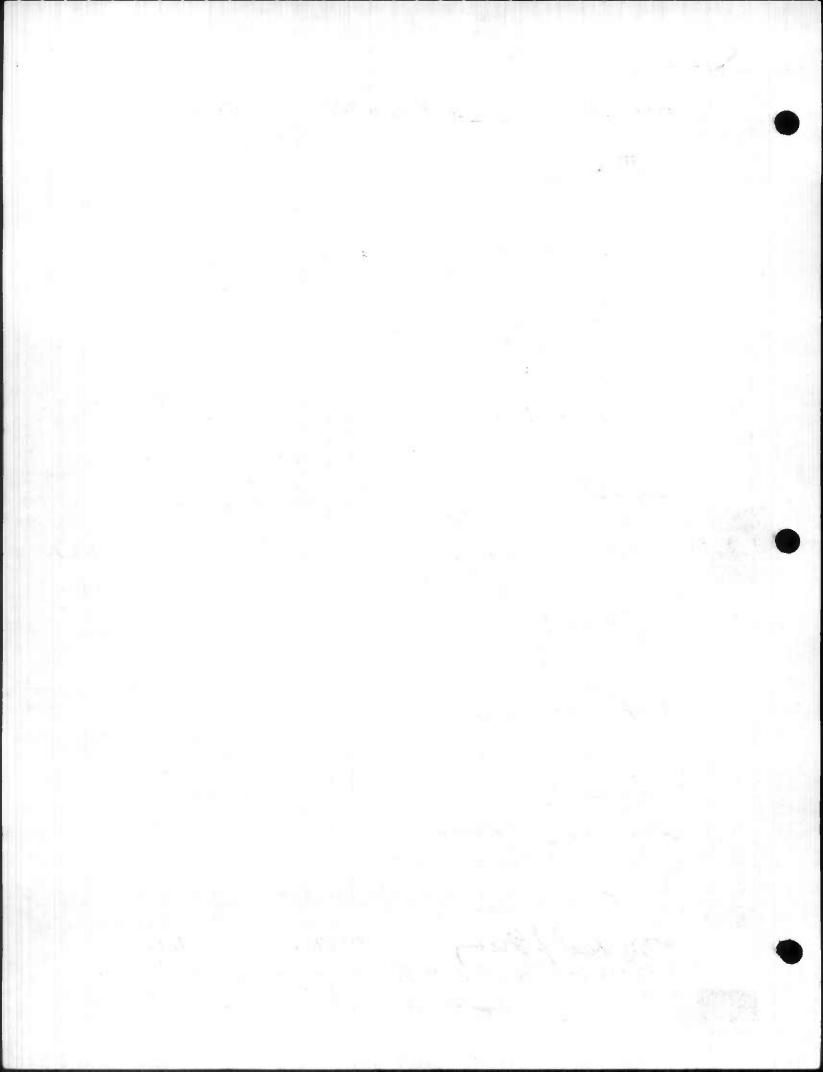
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State Registrar 32. Registrer's Signeture

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Jsuel Residence o	f Decedent		-									
0a. State 10b. County 10c. City, Town or Loca MD MONTGOMERY SILVER SI						G						10d. Inside City Limit
0e. Street and Nu	mber				10f. Zip	Code			10	g. Citizen of	What Cou	intry?

20901

1 Yes 2 No Specify:

Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

USA

#304 Silver Spring, MD 20902

14. Race - American Indian.

16b. Kind of Business/Industry

WHITE

Funeral Director

Physician

/Medical

Examiner

Director

Funeral

þ

5. Social Security Number

703 NORTHWEST DRIVE

15. Decedent's Education (Specify only highest grade completed)

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates:

334 24 7287

10e. Street and Number

10a. State

the Maryland 28a-f b Вета 23а

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Item 'natural', or I mportant: If Item 27 is marked other iny injury or other traumatic event, it

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed 89 signed by the atte should should page 2 certificate funeral director. this Atter within 24 hours after death. To the Funeral Director: A filled in by

Division of Vital Records, P.O. Box 68760,

12

State

Registrar

Examiner Physician/Medical þ Completed Be Medical Certification: To

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahadori

FEB 04 2000

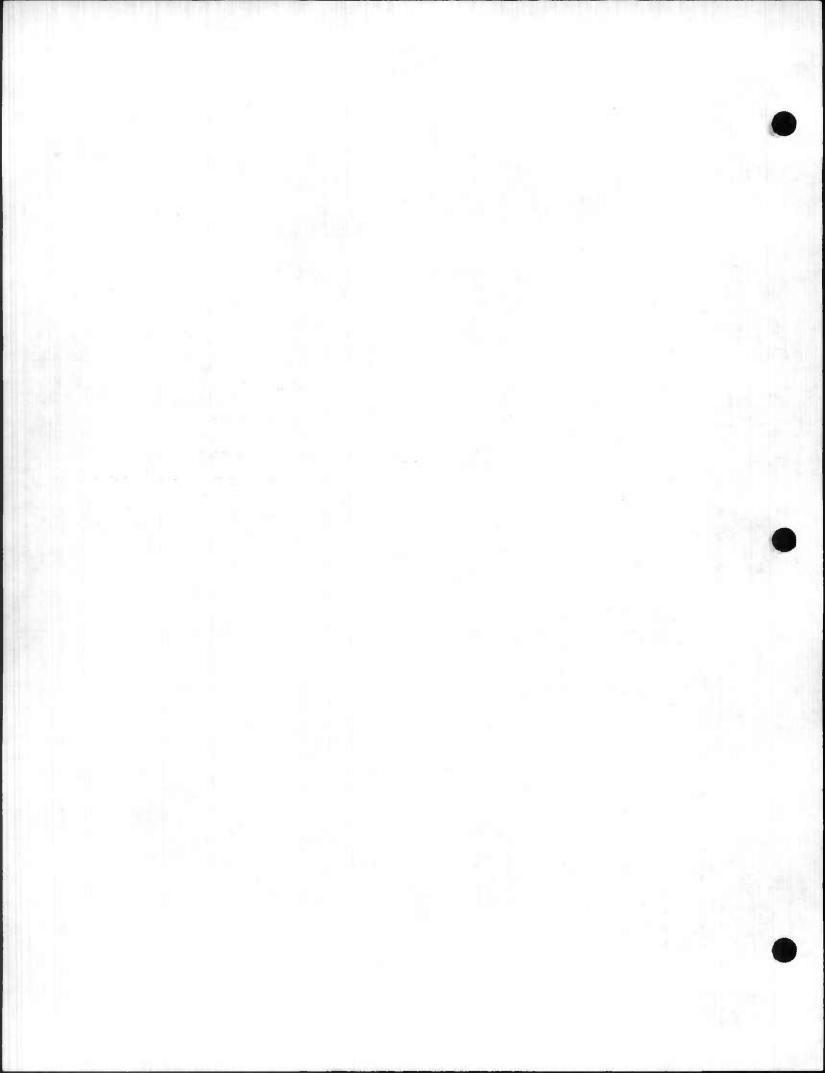
31. Date filed (Month, Day, Year)

10301 Ceorgia Are 32. Registrer's Signeture

D47928

Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DEPARTMENT OF Elementery/Secondary (0-12) College (1-4or 5+) BIO CHEMIST AGGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER GEORGE ROMANOWSKI MARY TOMASZEK 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL ROMANOWSKI (SPOUSE) 703 NORTHWEST DRIVE SILVER SPRING, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State FORT LINCOLN CREMATORY 2-7-2000 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility NES-RINALDI 11800 NEW HAMPSHIRE 21. Signst@Wol Funeral Service Licen-AVENUE SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Daeth Immediate Cause (Finel MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): ISCHEMIC CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer?
1 ☐ Yes 2 ☒ No 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

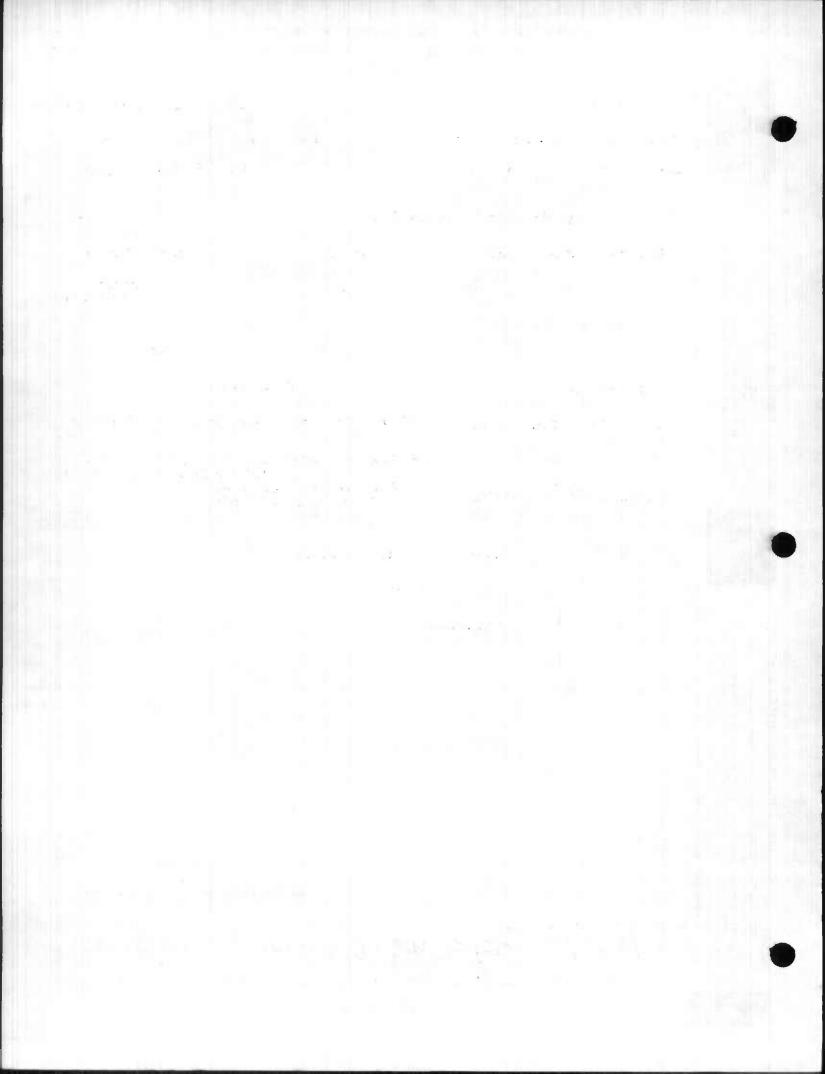
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 14597

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month Yeer **Physician** Annie 29 2000 10:00 AM Jan. /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Mariner Health Center of Kensington Kensington Montgomery H Under 1 Year If Under 24 Hrs. S. Dete of Birth Months Deys Hours Min. July 29, 1907 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Georgia 1 □ M 2 🛛 F 92 253-01-6530 Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County "natural", or items 23a or 28a-f show solical Examiner must be notified at XX Yes 2□ No MD Prince George's Director Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 and of Health Hygiene. Int! If ferm 27 is marked other than "natural", or flerms 23a or 3 and 20 or other traumatic event, the Medical Experiment must be any 5821 Queens Chapel Road 20782 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. African 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: American à 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Chef Catering 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Unavailable Unavailable 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 7138 Ora Glen Court Greenbelt, MD 20770 Michele Joy - Goddaughter 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriet 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 2/3/2000 Silver Spring, MD 22. Name end Address of Fecility McGuire Funeral SErvice, Inc. 21. Signeture of Funerel Service Licansee 7400 Georgia Ave., N.W. gull Washington, D.C. 20012

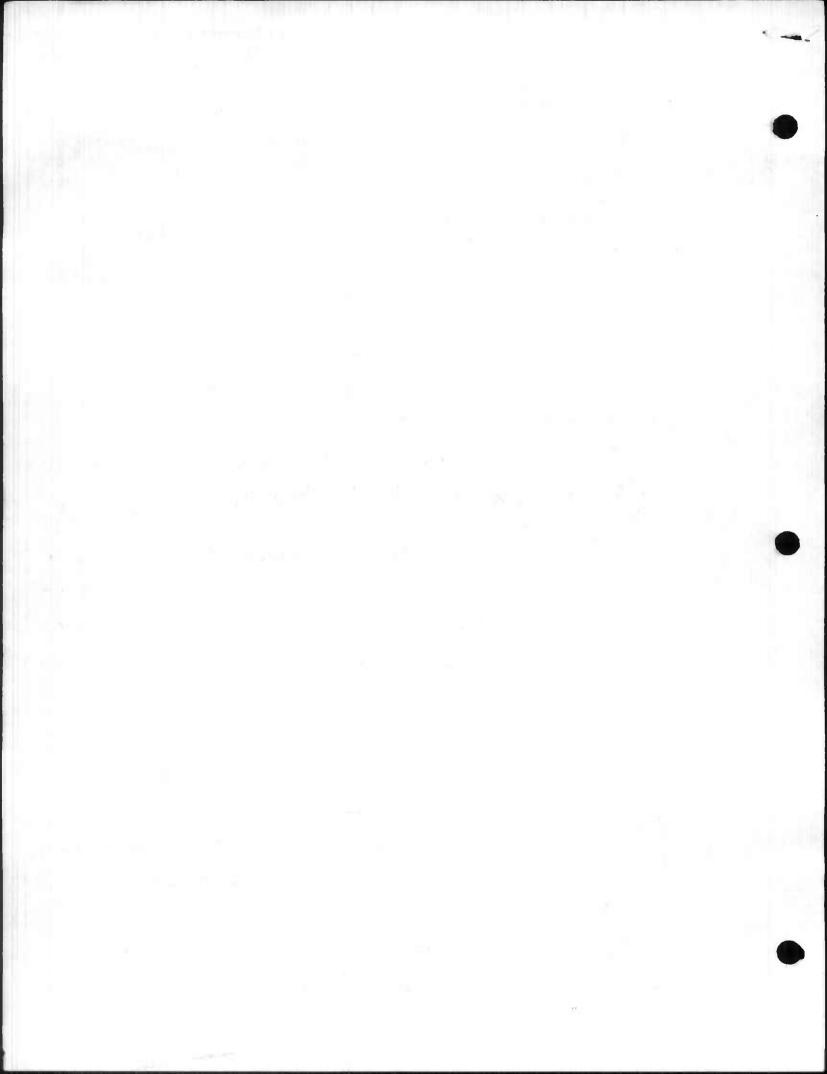
23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final Cerebral Vascular Accident disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Diabetes Mellitus physician and the bunal-transit law requires that the death certificate be executed Sequentielly list conditions, if erry, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Hypertension Physician/Medical Due to (or es a consequença of): 98 188 0 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Š 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed certificate has blirector, page 2 s The 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Aftar this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: or Attending 5 Pending investigation 12CNeturel 1 ☐ Yes 2 ☐ No death. ector: / 2 Accident n 24 hours after dea ne Funeral Director nietely filled in by th 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Hospital 29e. Certifier 1 Certifying Phyeicten: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated edical To the Hosp within 24 hos To the Fune completely fi (Check only 2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) and menner steted. onel 29b. Signature and title of centile 29c. License number 29d. Dete signed (Month, Dev. Year) 00 0022840 of person who completed cause of deeth (Item 23e) (Type, Print) Tape, M.D. 12201 Plum Orchard Drive, Silver Spring, MD Hazel/ 20904 31. Dete filed (Month, Dey, Year) 32. Pegistrer's Signeture State souls FEB 03 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 4598

		A	mended item#26 1/	31/00 FCHD			ificate of	Death		Reg. No.		
	Physic /Medi			Rice					2. Date of De Month Jan.	Dey	Yeer	3. Time of Death 2:10 PM
	Exami		4e. Facility Neme (If not institution, g					4b. City, Town, or Lo				2.10
			1846 Murdock Co					Frederic			reder	ick
	Funeral Director		218-56-5266	Sex 7. Ag	e (In yrs. last	birthday) Yrs.	Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De 8-12-1	th y, Yeer) 949		olece (State or Foreign htry)
	and .		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, To	own or Loca	ation					Od. Inside City Limits
	Many!	5	MD Freder	ick								T Yes 2 No
	1 the	Jec.	10e. Street end Number	ICA	ried	lerick	10f. Zip Coda			10g. Citizan of V	Vhat Coun	ntry?
	h with	Funeral Director	1846 Murdock Cour	st			2170	2.		TT	S.A.	
	dea	ner	11. Maritel Stafus	12. Wes Decedent Armed Forces?	Evar in U,S.	13. W	as Decedent of H	lispanic Origin? (Spen, Mexican, Puerto	ecify Yes or No		a - Americ	ean Indien,
21215-0020	s within 72 hours after death with the Maryland liene. Then "natural", or ferms 23a or 28a-f show the Medical Examiner must be notified at	þ	1 Never Merried 2 Married 3 Widowed M Divorced				Yes 21 No		nican, etc.)		whie,	
5-0	72 hc	Completed	15. Decedent's (Specify only highest g	Education	16	6a. Decede	nt's Usuel Occup	etion during most of work	ina	16b. Kind of Bu	siness/Inc	dustry
121	within and the state of the sta	mpigm	Elementery/Secondery (0-12)	College (1-4or 5	5+)			during most of work		Laidla	1747 Tr	ng
	10 to 15 to	ပိ	17. Father's Name (First, Middla, Las	0		AC	countant	18. Mother's Name	/First Middle			.IC •
Maryland	e d la p	o Be	James Rice	31/					Atkinso		10)	
ary		To	19e. Informent's Name/Reletionship	(Type, Print)	1	9b. Malling	Address (Street	and Number or Run			State. Zin	(Code)
			Ruth A. Rice/mot	her				Court,				
Baltimore,	Pages 1 end 2 lent of Health nt: If item 27 I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3		cema	of Disposi Itary, creme	tion (Name of story or other plea	ce)	Dete	20c. Location -	City or To	own, Stete
ŧ	emit. Pages epartment of reportant: If it ny injury or o		4 Donetion 5 Other (Spec	1	Restn	aven	Memorial Name end Addre	Gardens	1/29/00	Frederi	ck, N	MD 21701
Ba	Dap Impo		1.111		Soun,	IO	acuro C+	oin Too	, 230 E Sykesy	Baltimor	e Ave	e dersburg. N
	Physician		23a. Part 1. Enter the disease, or co- shock, or heart failure. List only	0						rrest, 2.178	1	Criser end Deetin
	/Medical Examiner		Immediete Causa (Final disease or condition resulting in death)	e. Car	Due to for es	a conseque	onary ence of):	Arr	est			8 min 15 min 15 min
	pet usit	Examiner		ı b. //	Sphi	ixia	tion enca of):					15min
,	ificate be executed g physician and as the bunal-transit	Exar	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying	, ,	Due to (or as	e conseque	enca of):				i	1-
68760,	e be Sicia	edical	thet Initieted avants		angi Due to (or/as		noce of):					13111
	25 00 6	100	rasulting in death) Lest	Time								5
Box		N/ue		1 d	epre	551	000					years
	the death cer y the attendir sched for use	Physician/N	Pert II. Other significent conditions	contributing to death bu	ut not resulting	g in the und	lerlying cause giv	en in Pert I.	23b. DId	tobacco use cor	ntributa to	the cause of death?
s, P.O	es that the de igned by the a	by Phy							10	Yes 2 XNo	3 Prot	bably 4 Unknown
Records,	been s	Completed I								an autopsy med?	ave cor	ere autopsy findings elleble prior to mpletion of cause death?
	The ate h	Com							10	Yes 2 No	1 🗆	Yes 2□ No
Vital	Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical axaminar?					26. Place of Deatl	(Check only o	one)		
of	Q 50 X	L C	1 Yes 2□ No	Hospitel: 1 Inpatie		Outpetient		4 LI Nursing Ho	-	denca 8 □Oth		y)
UC	fing After fune	Certification:	27. Mannar of Deeth 1 ☐ Neturel 5 ☐ Pending	28e. Date of Injur (Month, De)		. Time of Injury	28c. Injur Wor		28d. Describe	how injury occur	ea .	//
Division	il or Attending effer death. I Director: After d in by the fune	fical	2 Accidant investigati 3 Suicide 6 Could not	be all Block of University	00 a		7		28f. Location (offict e Street and Numb		Tanging
<u>S</u>	or A series of the Directory	erti	Homicide datamine	building, ato	(Specify)	1			City or To	vn, Stete)	.047	Transfer the
	Hospita 24 hours Funeral tely fille	edical C	29e. Certifiar (Check only one) Certifying P Medical Exa	hyelcian: To the best of miner: On the basis of	examination a	10) Ige, daeth d and/or inve	occurred et tha tir	ne, data end plece, pinion, deeth occurr	end due to the ed at tha tima,	ceuse(s) end ma data and placa,	inner as st	teted.
	To the within 2 To the comple	Mec	29b. Signetura end title of cartifier	end manner sta	neu.		29c. Licens	e number		29d. Date signe	d (Month. i	Day, Yeer)
	F ₹ F 0		10. 9	V.	1/1		7					
			30. Neme, and eddress of person who	completed cause of de	Sath (Itam 23s	e) (Type. Pr	rint)	01111		1-0	8-6	10
			Alan Rober	er MD		W.	Par	trick .	St. 7	redor	rick	DD 21703
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registre	or's Signeture	40	4	/			1	



00 - 023

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Months

10f. Zip Code

04599

Warren	Keith	Stewart
--------	-------	---------

Directo

Funeral

þ

Completed

86

Physician/Medical Examiner

by

Completed

Be

To

Certification:

Medical

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Warren Keith Stewart JANUARY 22,2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner N/A

7. Age (In yrs. last birthdey)

*Funeral Director

28a-f show

iero. 'then "natural', or litema 23a or 28a-f the Medical Examiner must be notifis

72 hours after

should be filed within and Mental Physiene.

Pages 1 and 2.s ment of Health an

Mem 27

other other

marked

ä

ò

Important: any injury once.

Baltimore, Maryland 21215-0020

214-98-3499 Usual Residence of Decedent 10a. State Md

5. Social Security Number

10b. County Baltimore 10c. City, Town or Location Halethorpe Hours

If Under 1 Year | If Under 24 Hrs.

Days

21227

BALTIMORE

8. Date of Birth (Month, Dey, Year) May 5 1968

9. Birthplace (State or Foreign Country) Md

10d. Inside City Limits 1 Yes 2X No

3. Tima of Death

9:16P.M.

10e. Street and Number 4313 Washington Blvd.

12

1X Never Merried 2 Married 3 Widowed 4 Divorced

ST.AGNES HOSPITAL

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2/2 No If Yes, Give Yeer or Detes:

31

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐XNo Specify:

14. Rece - American Indian. Bleck, White, etc.

16b. Kind of Business/Industry

10g. Citizen of What Country?

Specify: white

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12)

College (1-4or 5+)

100M 2□ F

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) truck driver

trucking

USA

17. Father's Neme (First, Middle, Last)

Woody Daryl Stewart

18. Mother's Neme (First, Middle, Maiden Sumeme)

Ruth Marie Strand 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

19e. Informent's Neme/Relationship (Type, Print)

7120 Marston Rd., Baltimore, Md 21207

Woody Stewart (father) 20e. Method of Disposition

20b. Plece of Disposition (Name of cametery, cremetory or other plece) Green Lane Cemetery

20c. Location - City or Town, Stete 1-27-2000 Delray, WV

21. Signeture of Funerel Service Licenses

Paige Haight Herbert

22. Name end Address of Facility Haight Funeral Home & Chapel

P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Physician /Medical Examiner

and

the attending physician

should be det

page 2 s

certificate

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p.

use as the buriel-transit

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of)

Due to (or es e consequence of):

Due to (or as e consequence of):

24a. Wes an autopsy parlormed?

1 □ Yes 💥 No 3 □ Probably 4 □ Unknown

2 No

24b. Ware autopsy findings available prior to completion of cause of death? Yes 2 No

Approximete ervel Bety Onset and Death

25. Was case referred to medical XYes 2□ No

> 5 Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year) 22 00 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Hospital: 1 ☐ Inpatient 2 🂢 ER/Outpatient 3 ☐ DOA 28b. Time of Injury P

STREET

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. fnjury et Work? 1 Yes 2 No

26. Piece of Death (Check only one)

28d. Describe how Injury occurred

KEDESTRAIN STRUCK BY AUTO 281. Location (Street and Number of Rural Route Number, City or Town, Stete) WASHINGTON BIN. + (Light Ro. BALTIMOIE, MD

23b. Did tobacco use contribute to the ceuse of death?

29a. Certifier (Check only one)

27. Menner of Death

1 Natural

2 Accident

3 Suicide

4 | Homicide

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier

29c. License number O.C.M.E.

29d. Dete signed (Month, Dey, Year) JANUARY 23,2000

30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print)

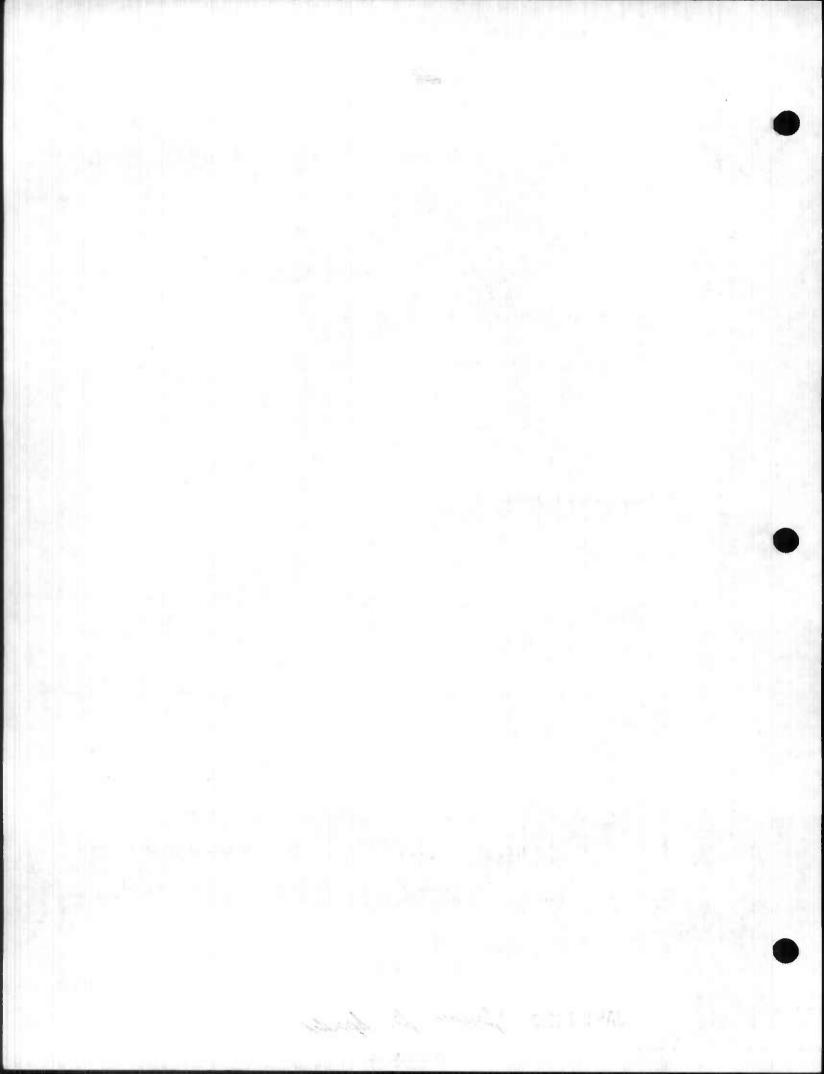
JACK M. TIMS, M.D 31. Dete filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

Registrar

JAN 3 1 2000

32. Registrar's Signeture



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Monih **Physician** SK: nner Bernice byce 4b. City, Town, or Location of Death 2000 11:45 PM 31 /Medical 4a Facility Name It not institution, give street and number) 4c. County of Dea Examiner Easton Genesis ElderCare Talbot The Pines If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 10M 20F 216-18-8756 Yrs. October 18 1917 Mary land Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 PYas 2 No Director albot Easton 23a or 28a-t 10g. Citizen of What Country? 10e. Streei and Number 10f. Zip Code Unionville Road

12. Was Decedent Ever in U,S.
Armed Forces?
1 □ Yes 2 Ø Ño US 2160 Funeral 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 P If Yes, Give Year or Datas: 1 ☐ Nevar Marriad 2 ☐ Married Joyce Skinng 1215-0020 'natural', or 1□ Yes 20 No Specify: Specify: þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Pages 1 and 2 should be Illed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private ResiDence 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surnama) 8 Department of Health and Mental Important: If Item 27 is marked or (Tibson Harriet lifton KOBERTS 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9368 Union 1: 1/e Road Easton, Mary land 21601
ce of Disposition (Neme of Date 200. Location - City or Yown, State Bailey 5 ORIa 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 1 Burial 2 □ Cramation 3 □ Removal from State 2/07/2000 teran's Cemetery HURLOCK Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signalura of Funeral Service Licensee 22. Name and Address of Facility Home P.A. Henry Funeral 23a. Part1 Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disaase or condition resulting in death) Examiner Examiner RO physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initieted events resulting in death) Last P.O. Box 68760 BETES MELLITY Physician/Medical Due to (or as a consequenca of): CEREBRO VASCULAR ACCIDENT Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of degth? 3 Probably 4 3 Unknown 1 Yes 2 No DERTENSION been signed t should be det Records, py 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yas 2 No 1 Yes 2 No Division of Vital Depital or Attending Physician: hours after death. Ineral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2₽ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menne of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 | Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, (erm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Dis completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and financer steted. 29a. Certifier ş 29b. Signature and fittle of geruffeld 29d. Date signed (Month, Day, Year) 29c. License number 00 MAKAS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAKAS 508 IDLEWILD E. EASTON, IND 21601 DANIEL AVE 00

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 2 2000

32. Registrar's Signature

Lenger

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** Lucille O. Soltys 23, 2000 January 7:50am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Copper Ridge (710 Obrecht Road) Sykesville Carroll If Under 1 Yeer if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Sociei Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Months 1 ☐ M 2 🕱 F Hours 86 243-84-5844 **Director** Jan. 11, 1914 Illinois Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, fnside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner fruit be notified at Chestertown MD Director Kent 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Birch Run Road 21620 USA Funeral death 13. Wes Decedent of Hispanic Origin? (Specify Yes or Notit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after cartment of Health and Mental thygiene. ortant: if item 27 is marked other than "naturel; or ite injury or other traumatic avent, the leastest Engineen. 1 ☐ Yes 2 No 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 2 3℃ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Albert Uecker Olga Klug 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Martha Wefelmeyer (Daughter) 210 Birch Run Road Chestertown, MD 21620 Baltimore. 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from Stete pemit. Page Department of Important: If any Injury or once. Onslow Memorial Gardens 1/26/2000 Jacksonville, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensi 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400 shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final diseese or condition resulting in death) ADVANCED DEMENTIA Examiner Years Due to (or es e consequenca of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 certificate be Physician/Medical Due to (or as a consequence of): 88 980 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 has 1X Yes 2 □ No 1 ☐ Yes 2 No certificate Division of Vital funeral director, Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Patter death.

Director: After t 1 X Neturel 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

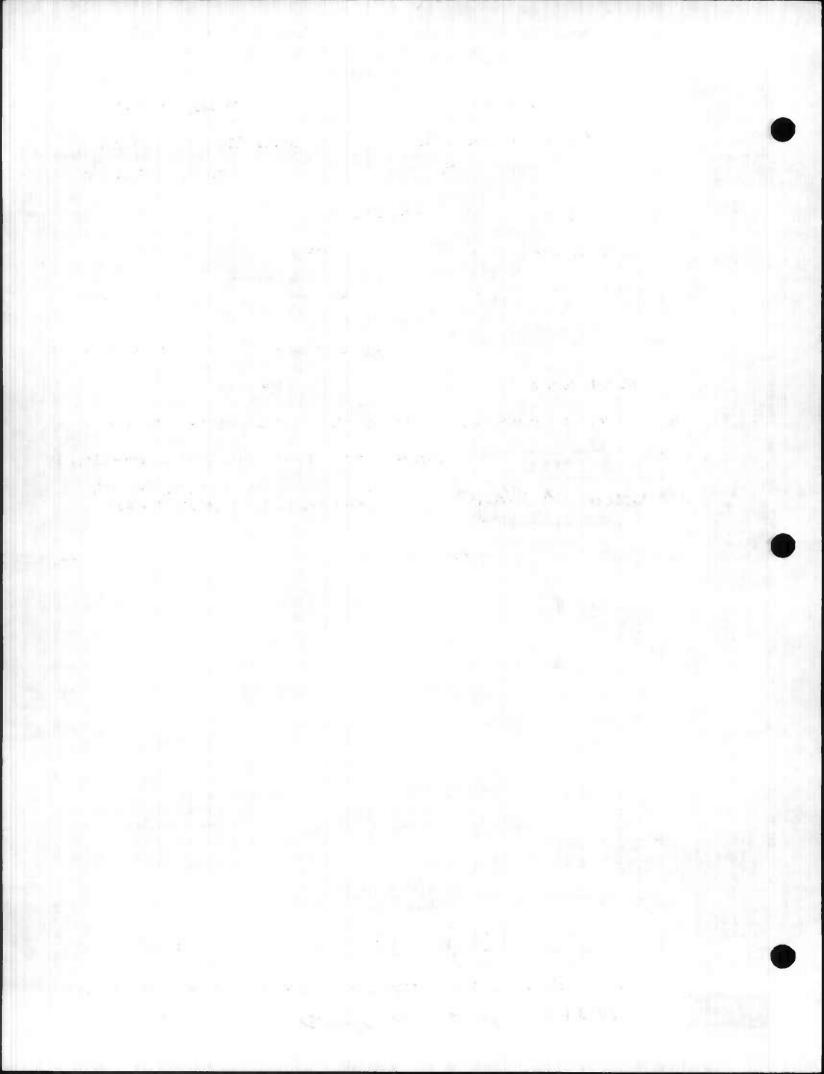
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edicai (Check only one) To the I 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and little of certifier D52740 January 23, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JAN 3 1 2000

32. Registrar's Signeture DENERA

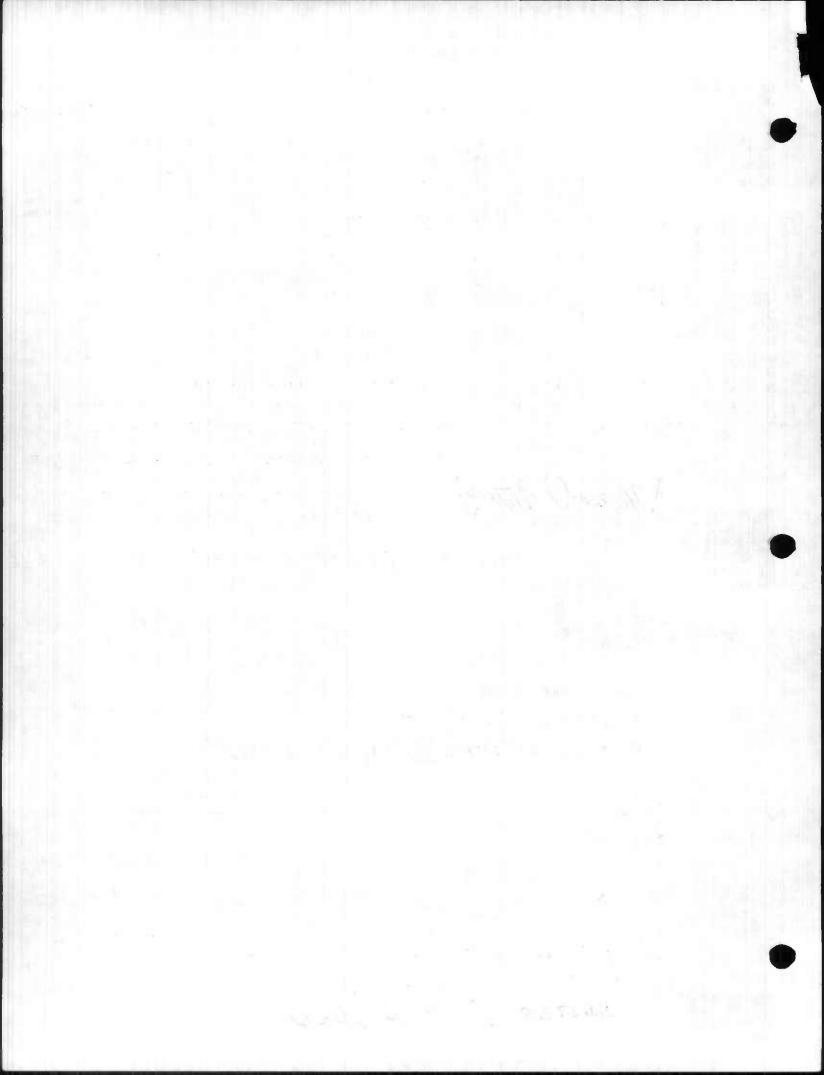
Ernestine Wright, M.D., Copper Ridge (710 Obrecht Road), Sykesville, MD 21784 Docker



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #26, per Phy. 01/27/2000, Carroll County, wil Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** HELEN ONEDA SEE JAN. 19, 2000 12:40 PM · /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nema (If not institution, giva street end number) Examiner DEER PARK MANOR WESTMINSTER CARROLL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yeer Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Deys 1□ M 2√2 F 37 Yrs. 213-05-1323 **Director** 11/28/1912 MARYLAND Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be institled at 1 Yas 2 No Directo MD. CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3550 NICHOLSON RD. 21157 USA. Pages 1 and 2 should be filed within 72 hours effer deeth nent of Health and Mental Hygiene.
Int: If Item 27 Ie marked other than "natural", or Itema 23 ary or other traumatic event, the Medical Exercities intust. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) Bieck, White, etc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3

Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) ASSEMBLY LINE MANUFACTURING 11 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fethar's Neme (First, Middle, Last) CHARLES CLAYTON MANCHA CORA MAE WAGNER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) -SISTER 3550 NICHOLSON RD., WESTMINSTER, MD. 21
20b. Place of Disposition (Name of Local L REBECCA L. KIBLER 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion ☑ Removel from State permit. Page Department of Important: If any Injury or pages. REST HAVEN MEM.GARDENS1/21/00 HARRISONBURG, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama end Address of Facility FLETCHER FUNERAL HOME 21. Signeture of Funeral Service Intelligence 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Peril. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical · ARTERIOGELEROTIC HEART DISEASE 5 485 Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 88 USB Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Y88 2 X No 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? ATRIAL FIBRILLATION 1 ☐ Yes 2 No or Attending Physicien: 25. Wes case referred to medical examinar? funeral director Be Assisted 26. Place of Deeth (Check only one) 1 Yes 2√ No Hospitel: Other: 4 Nursing Home Model 6 Nother (Specify) Living To 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpetient 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 Pending efter death. Director: Aft 2 No 1 Yes 2 Accident investigation 6 Could not be determined 3 Sulcide Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours e Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Implicate Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) end manner stated. To the 29b. Signeture and title of certifier 29c. Licansa number 29d. Date signed (Mgnth, Day, Year) s of person who completed cause of deeth (Item 23e) (Type, Print) O CROSSROPIOS 32. Registrer's Signeture JAN 2 7 2000 State Registrar



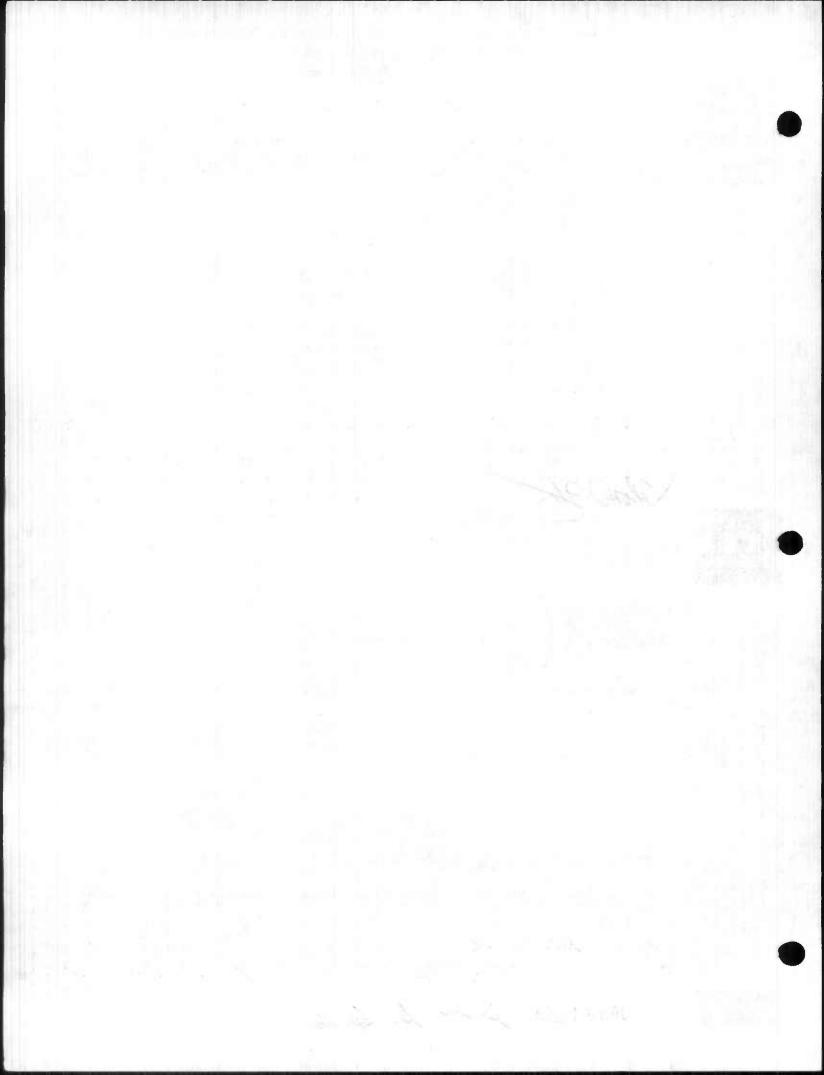
State of Maryland / Department of Health and Mental Hygiene 10 04603

						Certificat	e of	Death	Re	g. No.	0 4000
			1. Decedent's Name (First, Middle, Lest,)					2. Date of Death	1	3. Time of Death
	Physic /Medi		R	ALPH HAR	OLD SP	ENCER,	SR	2.	JAN. 2	8, 200	Year 00 3:00 AM
	Examir		4e. Fecility Name (If not institution, give	street end number)				4b. City, Town, or Lo		4c. County	The rate of
	7.1		WESTMINSTER NUR	SING HOM	Œ			WESTMIN	ISTER	CARI	ROLL
	Funeral Director		5. Social Security Number 6. Set 214-20-4827 Usual Residence of Decedent	x 7. Age ∏M 2□ F	o (In yrs. lest birt 75	thdey) If Under Months Yrs.	1 Yeer Days	If Under 24 Hrs.	8. Date of Birth (Month, Dey, 4 / 8 / 1 9		9. Birthplace (State or Foreign Country) MARYLAND
	fand		10e. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Mary Mary	tor	MD. CARROLL		WESTM	INSTER					1 ☐ Yes 2X No
	or 28	Director	10e. Street end Number			10f. Zip	Code		10	g. Citizen of V	Vhat Country?
	23a c		2932 SYKESVILLE	RD.		2	11	57		USA.	
20	be filed within 72 hours efter death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner roust be notified at	by Funeral	11. Meritai Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Yeer or Dates: (•KOREA	1 Vac		Hispanic Origin? (Special, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Indien, ck, White, etc.
Ö	2 hou	pa	15. Decedent's Edu			Decedent's Usue	i Occu	pation	1	6b. Kind of Bu	White usiness/Industry
21215-0020	e. Bn "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5	+)	(Give kind of wor life. DO NOT us	rk done se retire	during most of working)	ng	ob. Tand of Be	
	filed within Hygiene. Ither than "	Con	8		HE	AVY EQU	IPI	MENT OPE	RATOR	CONST	RUCTION
aryland	should be filed nd Mental Hygis marked other imatic event, the	Be	17. Father's Name (First, Middle, Last)					18. Mother's Neme	(First, Middle, M	le <i>iden Suma</i> m	(e)
<u>Z</u>	should the marked umatic a	10	HOWARD	SPENCE				EMILY			
Ma	12 sho h and is me		19a. Informent's Name/Reletionship (Ty					t end Number or Rum			
ē,	is 1 and 2 should of Haalth and Mer item 27 is marke other traumatic		JANE E. SPENCER 20a. Method of Disposition	-WIH		Disposition (Nen		ILLE RD.			R, MD. 21157 City or Town, State
imore,	Pages nent of int: If its iry or o		1 N Buriai 2 ☐ Cremation 3 ☐ R	lemovel from State	cemeter	y, cremetory or o	ther ple				
-	그 든 돈 등		4 ☐ Donetion 5 ☐ Other (Specify) 21. \$Ignature_of Funeral Service License		DEER I	PARK CE		FERY 1/	31/00 S	MALLW	OOD, MD.
Ba	Depa impo any i		2/m () 24					ess of Facility FL			AL HOME , MD. 21157
	_		23a. Part1. Enter the diseast, or compile shock, or heart failure.	cetions that caused	the death. Do n						Approximate
	Physician /Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)								Interval Between Onset end Deeth
		er		1	Due to (or es a c	consequence of):					
	executed in and iel-transit	Examiner	Sequentially list conditions)	Due to for as a c	onsequence of):					
Ó,	iceta be executed physician and s the buriel-transit		Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury	•	3 do 10 (01 do d 0	onsequence or).					
68760	death certificeta be e attending physicia od for use as the bur	edicai	that initiated events resulting in death) Lest	·	Due to (or es e c	onsequence of):		_			
	eath certific attending p	2									
Вох	ath o	ian		1.							
o.	the de	Physician/	Pert II. Other significant conditions con	tributing to death bu	t not resulting in	the underlying ca	ause gi	ven in Part I.	23b. Did tot	acco use cor	ntribute to the cause of death?
J.	as that the deligned by the a	y Ph	Dementin						1 □ Ye	• 2 ≥ No	3 Probably 4 Unknown
Vital Records,	aw requii is been s 2 should	Completed by							24a. Was an perform	autopsy ed?	24b. Were autopsy findings evalleble prior to completion of cause of death?
Y	0 - 0	Sor							1 🗆 Yes	s 2 □ No	1 Yes 2 No
ıta		Be	25. Was case referred to medical examiner?					26. Place of Death			
ō	Physician: r this certific rral director,	70	1 ☐ Yes 2 ☐ No H	lospital:		patient 3 DO	A Ott	her: 48 Nursing Hor	me 5 Resider	nce 6 Othe	er (Specify)
Division	or Attending P s aftar daath. I Director: After ti d in by the funera	Certification:	27. Menner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey	Year) 28b. T	ime of 2	Bc. Inju Wo 1	ry at rk?] Yes 2 □ No	28d. Describe how	w injury occurr	red
\leq	or Att aftar d Direct	ertifi	4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, fer (Specify)	m, street, factory	, office	•	28f. Location (Str. City or Town,		er or Rural Route Number,
	To the Hospital or At within 24 hours aftar of To the Funeral Direct completaly filled in by	edicai C	29a. Certifier (Check only one) 12 Certifying Phye 2 Medical Examin	iclan: To the best of ner: On the basis of and menner stat	examination end	death occurred a	at the ti	me, date and place, a opinion, death occurre	and due to the cered at the time, de	use(s) and ma te and plece, o	nner as stated. and due to the cause(s)
	To th To th Comp	M	29b. Signeture end title of certifier			29c	Licens	se number	29	d. Date signed	(Month, Dey, Year)
			Rul I.M.	-, MK	7	6	73	2092	/	1/28	(5000)
			30. Name and eddress of person who con	mpleted cause of de	ath (item 23e) (Type, Print)	r	Confee	O. 18	Printer	12000 12000
	Sta	te	31. Date filed (Month, Dey, Year)	32. Registra							

B. Spark

Registrar

JAN 3 1 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 04604 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2000 JAN. Joseph Scarcia, Jr. 29, 6:00A. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11007 Emack Road Beltsville Prince George's If Undar 24 Hrs. B. Date of Birth (Month, Day, Year) May 8, 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1₩ 2□ F Months Days 71 Yrs. 188-20-7263 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Prince George's 1 Yas 2000 Maryland Beltsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 11007 Emack Road 20705 United States 12. Was Decedant Evar In U.S. Armed Forces? YOX/es 2 □ No If Yes, Give Year or Dates: 1946–1949 Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexicen, Puerto Rican, etc.) Race - Amaricen Indian, Black, White, etc. 11. Marital Status 1 Never Married XX Married 1 ☐ Yas 200 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) Contractor Construction 12 18. Mothar's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Scarcia, Sr. Maria Paoletti 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Carolyn K. Scarcia (wife) same as #10 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriai 🏖 Cramation 3 ☐ Removal from Stata Metropolitan Crematory 1/30/2000 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa (re of Funeral Service Liceum Dönald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter tha diseasa, or complice shock, or heart failure. List only one aligns that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death Immediata Causa (Final disaasa or condition resulting in daath) Cardiomyopathy
Dua to (or as a consequence of): years Coronary Artery Disease
Due to (oras a consequence of): Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Diabetes years Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cancer with metastasis 24b. Wara autopsy findings available prior to completion of cause of death? Renal insufficiency 24a. Was an autopsy performed? Peripheral Vascular Disease 1 ☐ Yes 2 € No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred 5 Pending

Examiner physician and the burial-transit Records, P.O. Box 68760 980 Division of Vital After

Physician

/Medical

Examiner Physician/Medicai þ Completed Be

Physician

/Medical

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Director

Funeral

by

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental hyglene.

Int: If item 27 is marked other than "naturel", or items 23s or 28s-f show any or other transmit over the man be notified at any or other transmit be notified at

Baltimore, Maryland 21215-0020

or Attending Physician: after death. n 24 hours a Hospital within 24 hor To the Fune completely fi To the

12

25. Was cese referred to medicel axaminar? 1 Yes 2 No 27. Manner of Daath 1 Natural 1 Yes 2 No invastigation 2 Accident 6 Could not be datermined 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 12 Cartifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated. 29a. Certifier

(Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

dawn broduck

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)

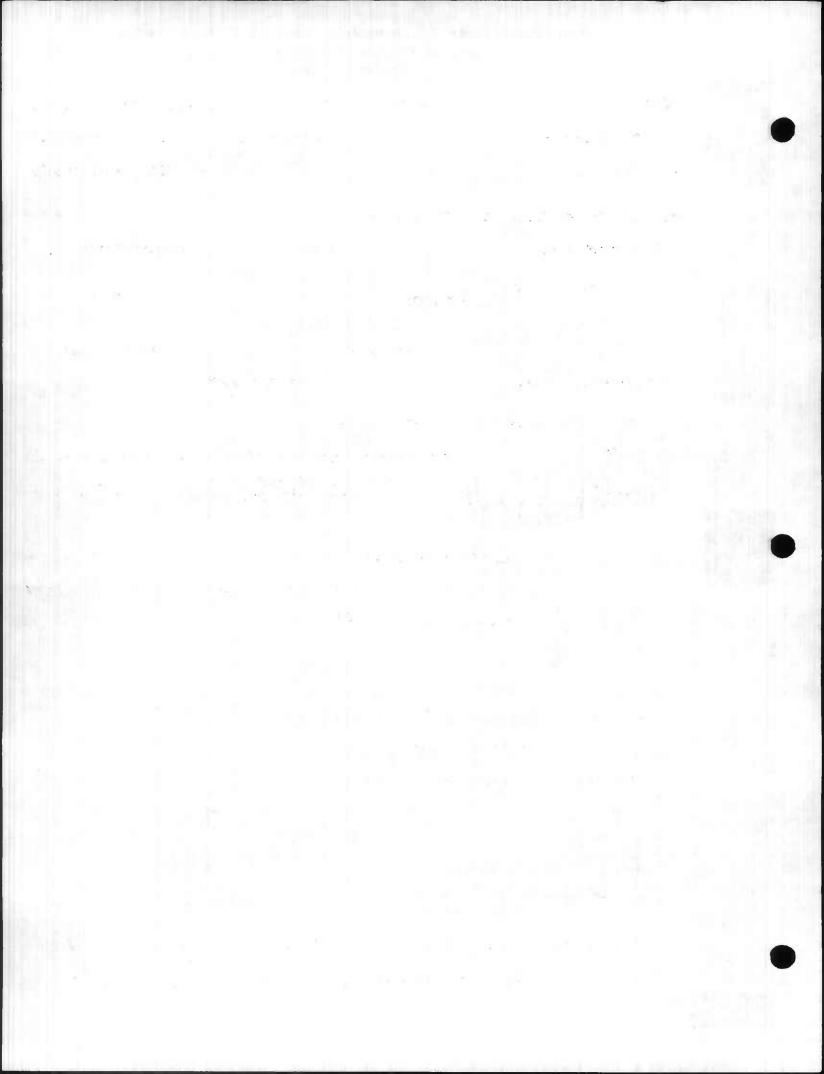
Dawn Broderick M.D. 18111 Prince Philip Dr. 712 Olney, MD20832

State Registrar

Medical

31. Date filed (Month, Day, Yaar)
JAN 31 2000

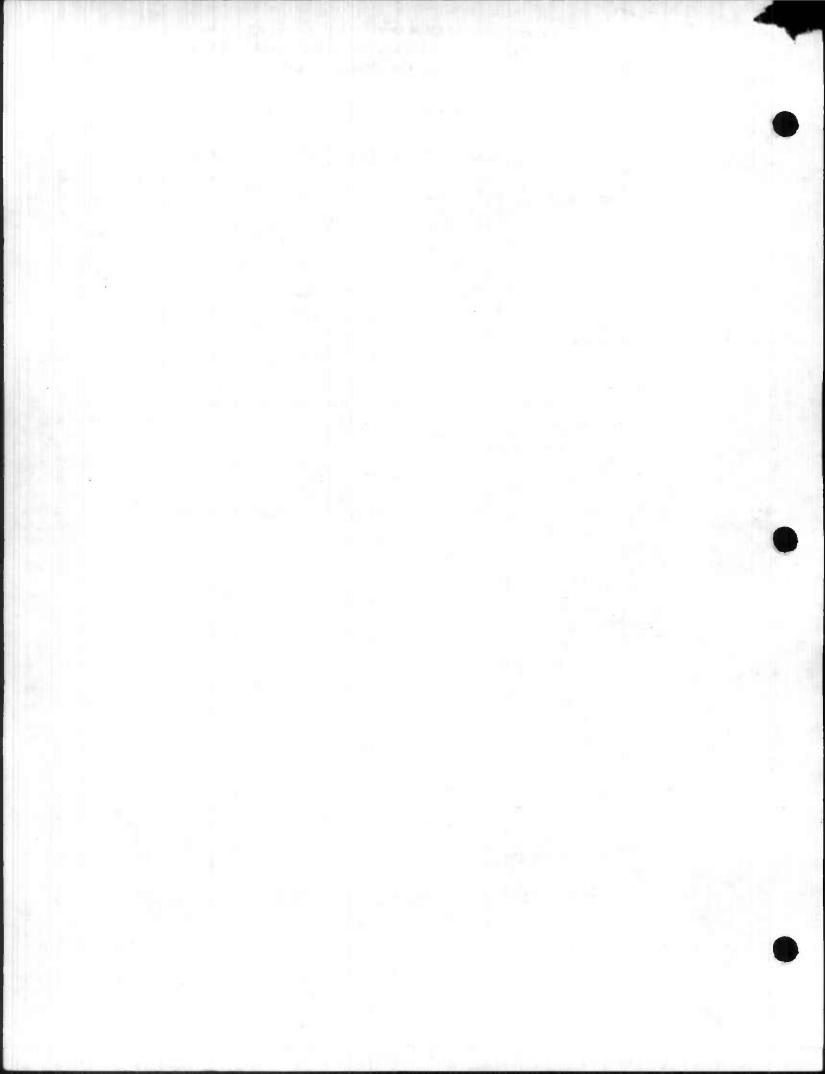
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 2000 MAXIM 24 6:09 AM SCOLNIK /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Sacurity Number 6. Sax 120 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Months 007-09-0182 Director 85 5/25/1914 MAINE Usual Rasidance of Decedent the Manyland 10a. Stata 10b. County 10c. City. Town or Location then "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 10d. fnside City Limits 1XXVes 2□ No Director MONTGOMERY MONTGOMERY VILLAGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v Funeral 10712 WAY RIDGE DRIVE 20886 USA 12. Wes Decedent Evar in U.S. Armed Forces? 1/2 Yas 2 No If Yas, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Merital Status Black, Whita, atc. 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 24 No Specify: Specify. by 3XXWidowed 4 ☐ Divorced Yeer or Detes: WWII WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Pages 1 and 2 should be filed within innent of Health and Mental Hygiene. ant: If item 27 is marked other than "I ury or other traumatic evant, the Mex Elamantary/Secondary (0-12) College (1-4or 5+) 5+ ATTORNEY VETERAN'S ADMIN. Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be JOSEPH SCOLNIK HANNA SCOLNIK 19s. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9489 GOOD LION ROAD, COLUMBIA, MARYLAND 21045 AL SCOLNIK (SON) 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta Dete XXBurial 2 ☐ Cremation 3 ☐ Removal from Stata Department Important: If any injury o 4 ☐ Donation 5 ☐ Othar (Specify) JUDEAN MEMORIAL GARDENS 1/27/2000 OLNEY, MARYLAND 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 21. Signature of Funerel Sarvice Licenses 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23e. Part1. Entertha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only ona cause on aach line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disaasa or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of): Examiner CARDIAC ARREST ician and burial-trans Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) DIABETES Physician/Medical the Dua to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? o signed by the 1 Yes 2 No 3 Probably Winknown BRAIN TUMOR 20 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yas 2 🖾 No 1 Yes 2 No 25. Was casa raferred to medical axaminer? Be 26. Place of Death (Check only ona) uX yas 2 No Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) Certification: To 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA this funeral 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Invastigation Attending 1X Matural death. 1 Yes 2 No 2 Accidant 24 hours after deat Puneral Director: 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide 8 29e, Certifier Medical XXCertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of salities 29c. License number 29d. Date, signed (Month, Day, Year) 0 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addie Betherda, Md 20814 31. Oata filed /4: Georgetown RX 32. Registrar's Signatura State

Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04606 Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Francis Albert Shaffer 22 2000 0832 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death GARRETT COUNTY MEMORIACHUSP DAKLAND barret If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Yaer Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthdey) Days Months 1⊠M 2□ F 213-12-9188 76 Maryland April 6, Usual Rasidence of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ₺ No Maryland Montgomery Silver Spring 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 3803 Woodridge Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedant Evar in U,S. Armed Forces? 14. Race - Amarican Indian, 11. Merital Stetus Bleck. Whita, etc. 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Merried 2 ☑ Married 1 Yas 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) Collega (1-4or 5+) 5+ 12 Attorney Legal 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Elzie Shaffer Theodora Clark 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informent's Name/Ralationship (Type, Print) Emma Rhea Shaffer / Wife 3803 Woodridge Avenue, Silver Spring, Maryland 20902 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Steta Gate of Heaven Cemetery 01/28/00 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Addrass of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 torns, ations that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, only one cause on each line. 235 Part1. Enter the disee shock, or heart failure Approximate Interval Between Onset and Death Immediata Causa (Final Arterio sclerutic coronaryvasci disease or condition rasulting In death) Due to (or as a consequenca of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Dunknown

Physician /Medical Examiner

physician and the burial-transit

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should be det

certificate

To the Hospital or Attending Physician: within 24 hours siter death.

To the Funeral Director: After this certifica

within 24 hours stre To the Funeral Dir completely filled in

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Box 68760

P.O.

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Medical Certification: To

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Department of Health and Mental Hy
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any Injury or other traumented other

hours after

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disease or Injury that initiated events rasulting in death) Last

29b. Signeture and titla of certifian

31. Dete filed (Month, Day, Year)

JAN

30. Name and address of person who complated causa of death (Item 23s) (Type, Print)

2000

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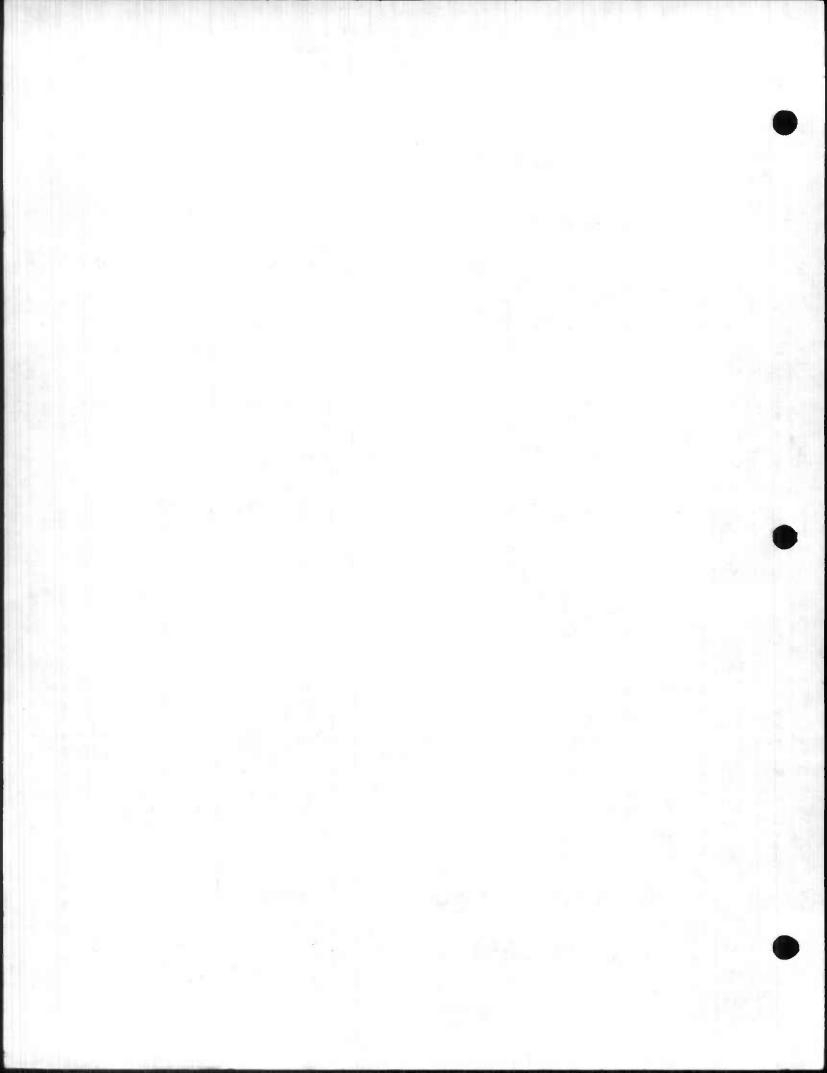
32. Registrar's Signatura

24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 SER/Outpatient 3□ DOA 1 Inpatiant 28a. Data of Injury (Month, Day Year) 27. Mennar of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of T- Natural 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 6 Could not be datamined 3 Sulcide 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homlcida 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar



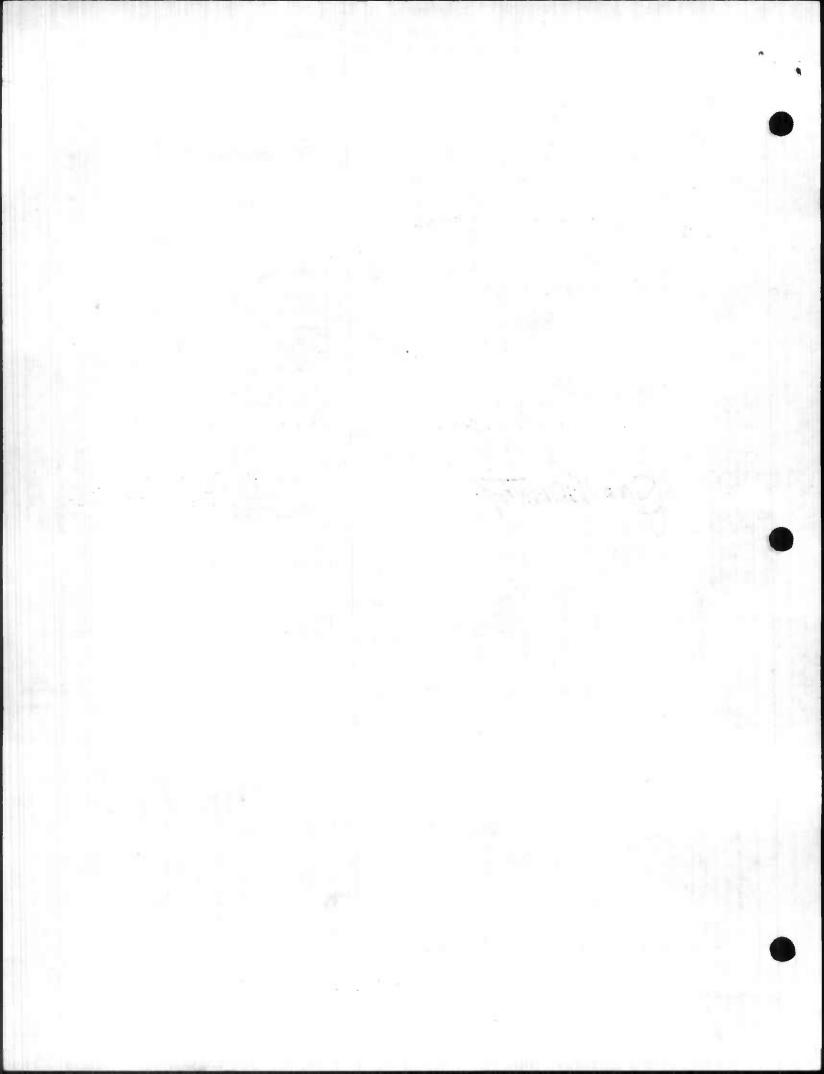
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 04607 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 20, 2000 9:35 A.M. JANUARY MARIAN STORREY SCHRAVESANDE /Medical 4a Facility Name (Il not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** POTOMAC MONTGOMERY MANOR CARE POTOMAC If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sax **Funeral** Days Hours Months 1□ M 2KX 92 Yrs. Director 578-48-8406 MAR. 28, 1907 COLORADO Usual Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits show 28a-f sh notified 1 Yes 2 No Director MARYLAND MONTGOMERY POTOMAC 2 10a Street and Number 10f Zio Code 10g. Citizen of What Country? b UNITED STATES OF AMERICA must be Herna 23a 20854 Funeral 10721 RED BARN LANE 12. Was Decedenf Ever in U.S. Armed Forces?

1 Yes 2 Tho If Yes, Give Yeer or Dates: 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 t. Marifal Stetus Black, Whita, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: þ 3℃Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n PRIVATE REMEDIAL Elementery/Secondery (0-12) College (1-4or 5+) SCHOOL TEACHER TUTORING 4 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) 86 Pages 1 and 2 should be I ment of Health and Mental I ant: If Item 27 is marked of CLARA PEARL MORRISON GEORGE W. STORREY 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important: if item 27 is n any injury or other MARIAN D. SCHRAVESANDE (DAUGHTER) 10721 RED BARN LANE; POTOMAC, MARYLAND 20854 Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Alemoval from State JAN. 24. 1 Burial 2 Cremetion 4 Donetion 5 Other (Speaky) FORT LINCOLN CREMATORY BRENTWOOD, MARYLAND 2000 of Funeral Six 22. Name end Address of FacilityHINES-RINALDI FUNERAL HOME, INC. ines inense 11800 NEW HAMPSHIRE AVENUE amau SILVER SPRING, MARYLAND 20904-2891 Enler the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart feilure. List only one cause on each line. 23a. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel a DEHYDRATION diseese or condition resulting In deeth) 1 WEEK Examiner Due to (or as a consequence of): Examiner YEARS b. DEMENTIA certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of) 987 ed by the e 23b. Did tobecco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1 Yes 2 No 3 Probably 4 Unknown The law requires that CHF Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed DEPRESSION page 2 s 1 Yes 2X No 1 TYes 2 No Division of Vital HYPERTENSION 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4XXNursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2KNo this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? Certification: Attending 5 Pending 1 K Wetural death. 1 ☐ Yes 2 ☐ No investigation 24 hours after death e Funeral Director: A pletely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 6 Hospital edical 29a. Certifie Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 4 D38781 JANUARY 21, 2000 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 20016 4910 MASSACHUSETTS AVENUE, NW, SUITE 312 WASHINGTON, D.C. M.D MICHAEL J. GRADY, 31. Dete filed (Month, Day, Year) JAN 31 32. Registrer's Signeture

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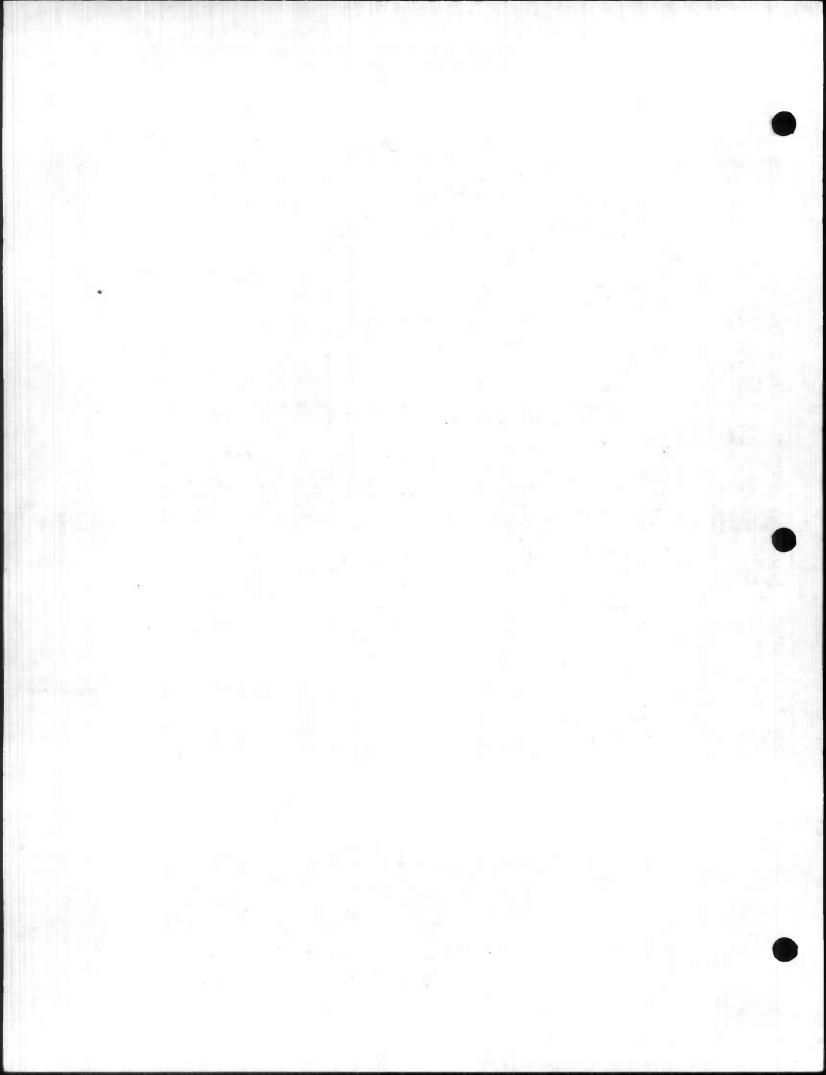
State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 4 6 0 8

			Certificate of Death	1	Reg. No.	04608
	Di		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ith Dey Yee	3. Time of Death
Ę.	Physici /Medi		Joan C. Smithson	Jan	31 200	
	Examir		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Death	4c. County of De	eath
			HOWGOOD COUNTY General Hospital Colum	701a	HOWK	ard
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	h 9. E	Birthplace (Stete or Foreign
	Director		216-50-5030 1 M 2 F 53 Yrs. Months Days Hours Min.	Sept.	4,1946 9.E	Maryland
	2		Usual Residence of Decedent			
	ahow III	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	N 18	cto	MD Howard Columbia			1 XYes 2 No
	# 9 F	Š	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	23 W	8	5460 Wildwind Place 21045		U.S.	Α.
21215-0020	7.72 hours after deeth with the Maryland "neturel", or heme 23e or 28e-f ahow dies Execute mes be notified a	by Funeral Director	11. Marital Status 1 □ Never Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No If Yes, Sive Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, WI Specify: B	
200	nafur Bear	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work.	ina	16b. Kind of Busines	ss/Industry
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	77 Co. h. ***	5	12th Equal Opportunity St	pec.	U.S. Go	vernment
9	0 5	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name			
<u>y</u>		0	Christopher Holland Dell	la L.	Copeland	
Maryland	nd 2 should lith and Mer 27 Is marks r traumatic		19a. Informant's Name/Relationship (Type, Print) Glenn E. Smithson (Husband) 5460 Wildwind Pl			
Baltimore,	Pages 1 an nent of Heel nt: If Nem 2 iry or other		20a. Method of Disposition 1⊠ Burial 2 □ Cremetion 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date / C / C	20c. Location - City	
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E C	Departi Departi Importu any inj		21. Signature of Funeral Service Licenses 22. Name and Address of Facility SNOWDEN FUNERA ROCKVILLE, MD	AL HOM 2085	E, P.A.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac			Approximate
7	Physician		shock, or heart tellure. List only one cause on each line.			Interval Between Onset end Death
A	/Medical		Immediate Cause (Finel disease or condition resulting in Ideath) Recurrent Aspiration	> A.	LINDAG	newitt
	Examiner		resulting in death) Due to (or as a consequence of):	012	W/MINO	- MOCKE
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>	Physician: rthis certific iral director,	ToB	axaminer? Hospital: Other:		dence 6 Other (S	inecify)
0	Phy prelie		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		now injury occurred	роспу
0	Att.	5	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
DIVISION OF VITAL	Attendi r deeth. ctor: A sy the f	Hoe	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office			Rural Route Number,
5	i Direct	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Tov	m, State)	
	To the Hospital or Attending Physician: The lev within 24 hours after deeth. To the Funeral Director: After this certificate heat complately filled in by the funeral director, page 2	calc	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, Check only Madical Fundings: On the basis of examination and/or investigation, in my opinion, death occurred.			
	he H in 24 piete	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	red at the time,	use and place, and c	iue to the cause(s)
	To t	2	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
	6		Kathleen yoll-fontly BY232		2-1	-00
		ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	0 (11	HILDON
			Kathleen YORK-Smith 9501 Old Annap	polis r	D Elli	2101/0
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			2045
	Registr	ar	FFB 0 4 2000 April 1			



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. 04609 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #26,2/1/2000, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 28, 2000 Betty Anne Royal Spiegel 9:30pm /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 419 Russell Ave. #507 Gaithersburg Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2X F Months Days Hours Min 78 Yrs. 010-20-8763 Director Feb. 17,1921 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r than "naturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at Md. Montgomery Gaithersburg 1 XYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Russell Ave. #507 20877 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Exercises DDCS. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5 + Foreign Affairs Officer Federal Government 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Kent Tyler Royal Lila Jane Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Judith Moore /daughter P.O. Box 1192 Abingdon, Va. 24212 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Date Jan. 29 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 2000 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licanor urles 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest shock, or heart failure. Liat only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical METMTATIL Immediate Cause (Final Brent conun 1045AR) disease or condition resulting in death) Examiner Examiner death certificate be executed attending physician and for use es the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) P.O. Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): signed by the a d be detached f 23b. Did tobecco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 XNO 3 Probably 4 Unknown 1 Yee Division of Vital Records. by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 has 1 ☐ Yes 200 No certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 8 Other (Specify) 10 1 ☐ Yes 28 No 1 ☐ Inpatient → ☐ ☐ DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of After Natural 5 Pending 1 Yes 2 No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signatury and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

2087

01257

DHMH 16 Rev 6/95

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Registrar

State

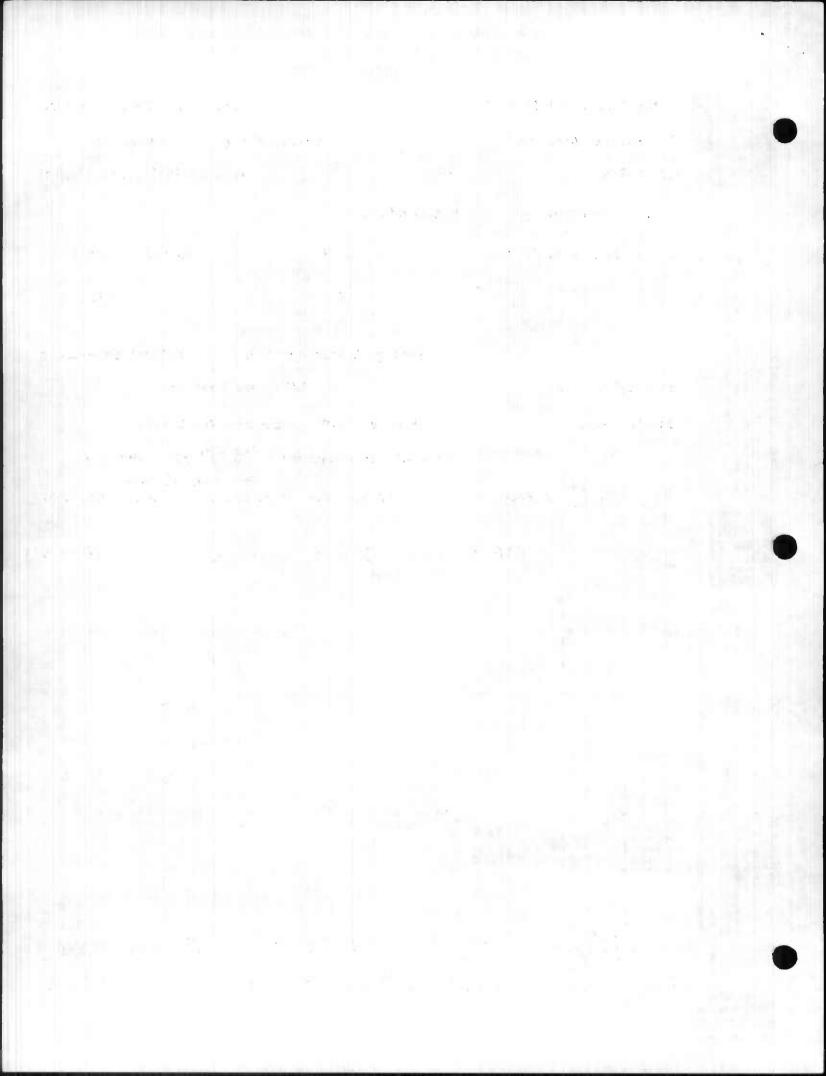
Know

2000

32. Registrar's Signature

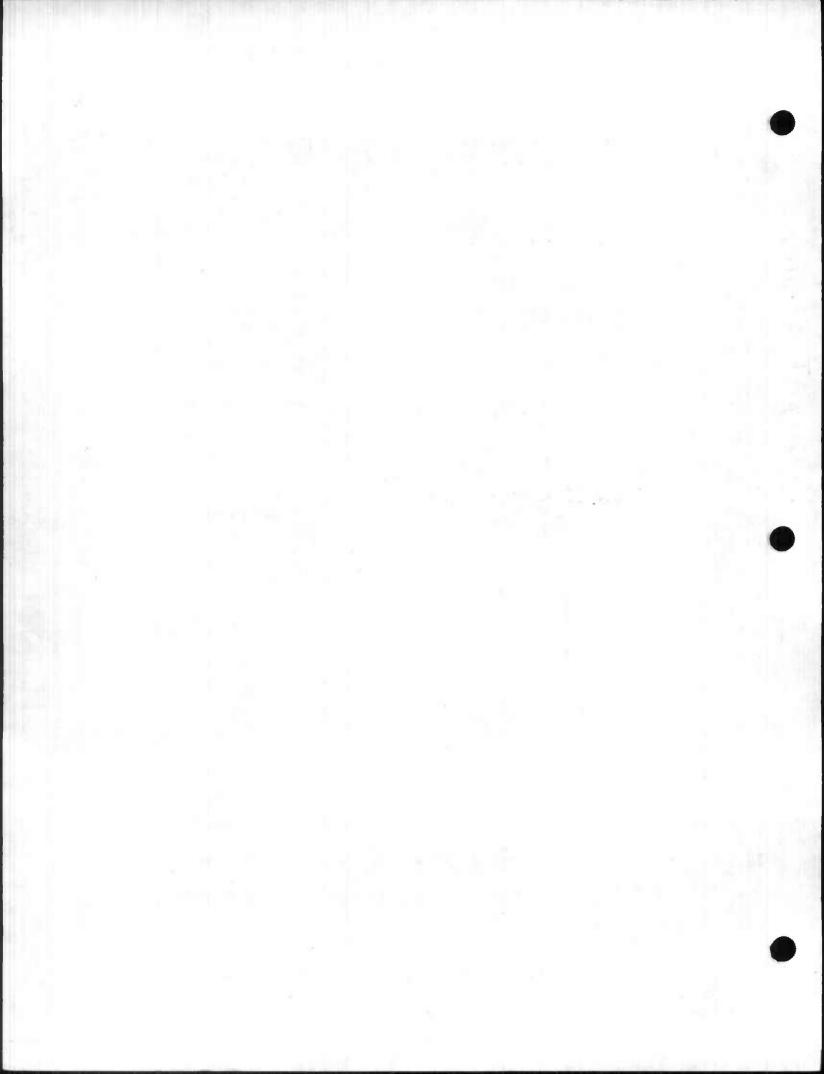
31. Date filed (Month, Day, Year)

FEB 1

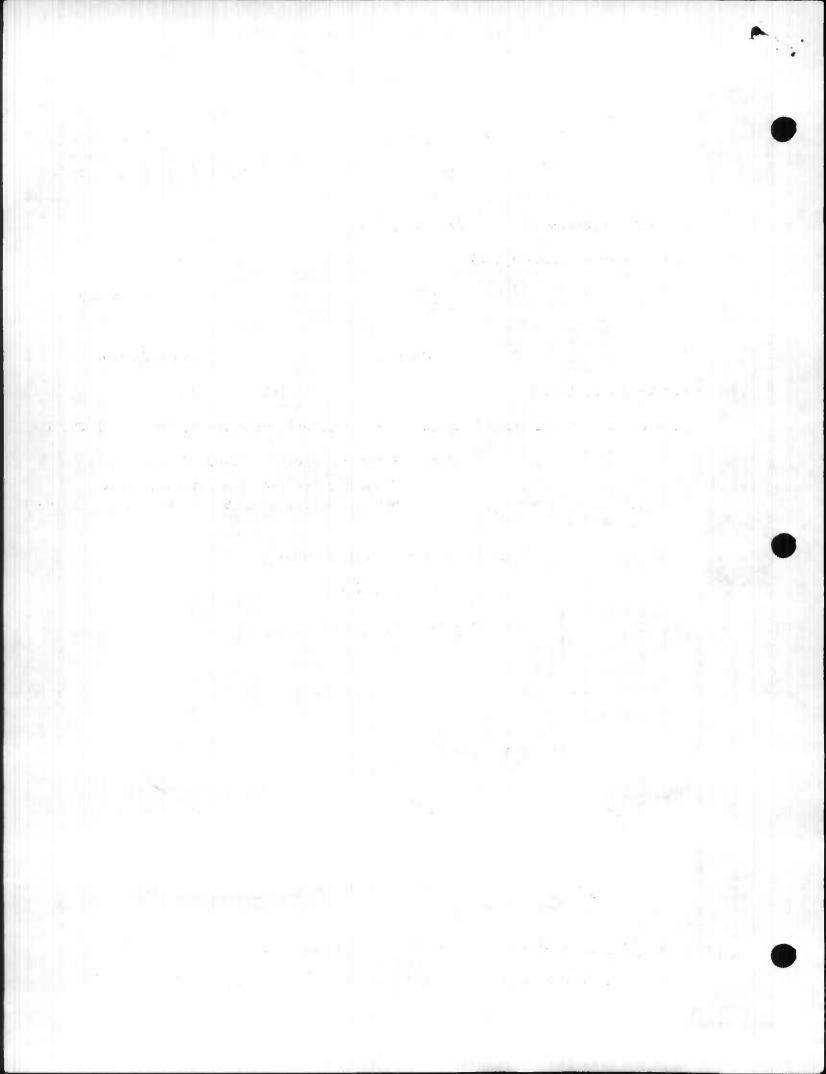


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death January :20 PM **Physician** 2000 EINES FRISH /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 0 HOPITOS If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Sociel Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 996-86-8038 10 M 20 F Months Days Hours Yrs. Director 89 October 23, 1910 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow any Injury or other traumatic event, the Mariania Examinar must be notified as any Injury or other traumatic event, the Mariania Examinar must be notified as any Injury or other traumatic event, the Mariania Examinar must be notified as any Injury or other traumatic event. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pompano Beach Florida Broward 1 Yes 2 No Funeral Director 10g. Citizen of What Country nited State 10e. Street and Number 3701 West McNab Road Apt 288 10f. Zip Code 33069 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Meritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Merchant Grocer 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hyman Terish Bessie Berger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 18 Marshall Street Watertown Mass. 02472 19151 19a. Informant's Neme/Reletionship (Type, Print) Harvey C. Steiner (Son) 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1⊠ Burlal 2 ☐ Cremetion 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Gardens 2/1/00 Falls Church VA 21. Signetura of Funaral Service Licensee Ballzansky Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner tau The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last pue Due to (or es a consequence of) the burial-trai P.O. Box 68760. Due to (or as a consequence of) for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yee 2 No 3 Probably 4 Unknown Records, py 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 2 No 2 No certificate Division of Vitai or Attanding Physician: funeral director. 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No To the Hospital or Attandit within 24 hours after death. To the Funeral Director: Al completely filled in by the fu death. 2 Accident investigation 3 Suicide 6 Could not be determined Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as etated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and menner steted. 29a. Certifier (Check only one) 29b. Signatura and titla of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D41365 January 28, 2000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive Glen Burnie 20061 Jicks TU 301 eorge 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State FEB 04 2000 Registrar

DHMH 16 Rev 6/95

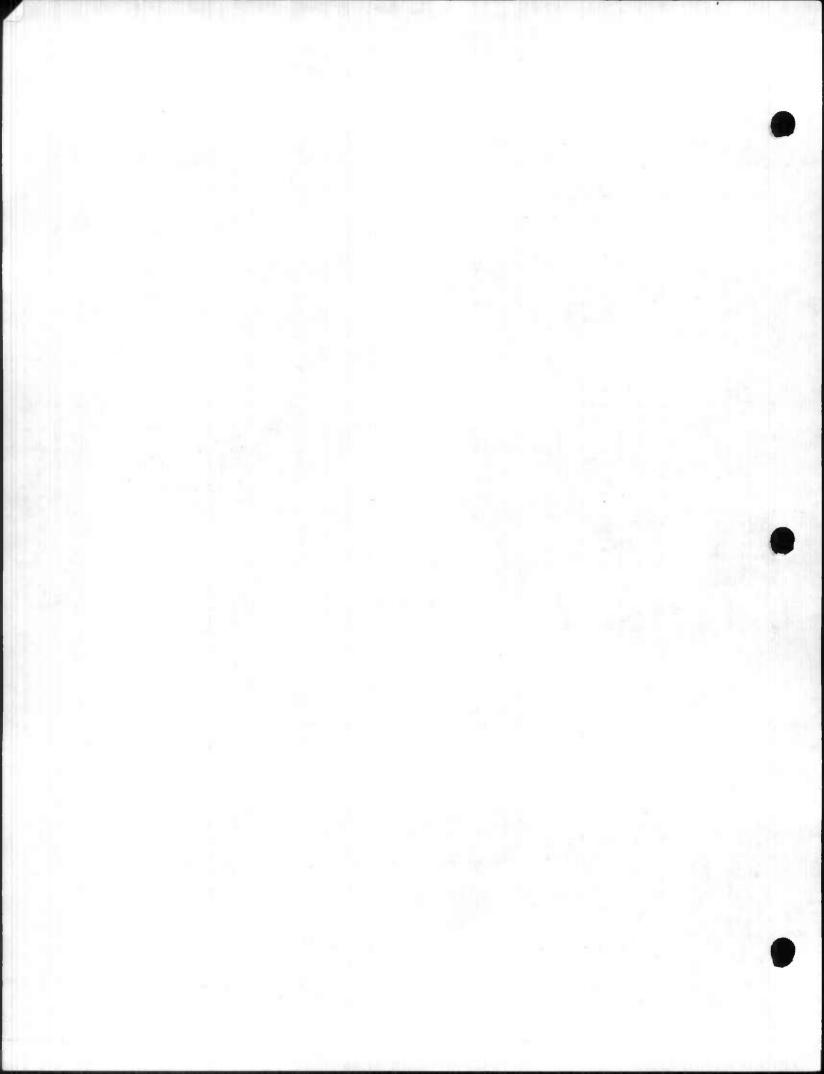


	2/2000, BMW, Montg. C 1. Decedent's Name (First, Middle, Las			f Death	2. Data of Death			ne of Death				
cian	Dohout John Ctd11					Jan.	26 -	Year D	702			
	Robert John Still As Facility Name (If not institution, give			/	4b. City, Town, or I		4c. County		,			
	Laurel Re	gional	Hospit	al	Lau	rel	Prin	ce Geo	rge's			
	5. Social Security Number 6. S. X	ex 7. A	ge (In yrs. last birtho 64 Yrs	Months Day		8. Date of Birth (Month, Day, March 6,	Year) 1935	9. Birthplace (Si Country) Pennsylv	ate or Foreign			
J	Usual Residenca of Decedent 10a. State 10b. County		10c. City, Town o	Location					de City Limits			
io M	Montgome			10	Yes 2 No							
7	10e. Street and Number		Silver S	10f. Zip Code		10	g. Citizen of V	What Country?				
runeral L	2024 Georgian Woo	ds Apt 13		20902		us	SA					
1	11. Marital Status	12. Was Decedent Armed Forcas	Ever in U,S.	3. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (S uban, Maxican, Puart	pecify Yas or No- o Rican, etc.)		e - American India ck, Whita, atc.	an,			
	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	No 1956- 1960	1 ☐ Yes 2 🛣 N	o Specity:		Specify	White				
r	15. Decedent's Ed (Specify only highest gra	ucetion	16a. De	cedent's Usual Occ	supation ne during most of wor	king 1	6b. Kind of Bu	usiness/Industry				
-	Elementery/Secondary (0-12)	College (1-4or	- In	e. DO NOT use reti	red)	Aniy						
		2	Cour	ier	40 Math and a Nice	S Contract of the second	Self-En	ployed				
L	17. Father's Neme (First, Middle, Last)					ne (First, Middle, M		10)				
-	Maurice M. Stiller 19e. Informant's Name/Relationship (7)		10h M	alling Address (Stre	Virginia et and Number or Ru	Johnsto		State 7in Code)				
									101			
2	Sandra Marie Stil 20a. Method of Disposition		20b. Place of D	sposition (Name of		nt Court,	Resto	City or Town, Sta	191 ite			
	1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ditan Cre	ematory	1/29/00	lavand	rio WA				
-	21. Signature of Funeral Service Licen		Hetrope									
Francis J. Collins Funeral Home, Inc.												
	23a. Part Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.											
	Immediete Cause (Finel disease or condition	Duli	MOHON	Phala	licm							
	resulting in death)	a.	Due to (or as a cor	sequence of):								
edicai Examiner	4	b. H.	ypothy	widisn	h							
	Sequentially list conditions, if any, leading to immediate		Due to (or as a cor	sequence of):								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c. HYPPV ten CIOL											
	that initiated avents per lio (or as a consequenca of): resulting in death) Last											
	d											
	Part It. Other significant conditions co	ntributing to death	out not resulting In th	e underlying cause	oiven in Part i	23b. Did to	Dacco usa co	ntributa to the ca	uss of death?			
ľ	a other signmount continues	announg to death !	out not resulting in th	o andonying couse	government die f.		2 DNo		4 Unknown			
1	sepsis											
	Recnin	Dha -	fail Out			24e. Wes en	n eutopsy nad?	24b. Were euto available	prior to			
	The spiva		141yaq					completion of death?	n of ceuse			
		9				1□ Ye	s 2000	1 Yes	20 No			
1	25. Wes case referred to medical axaminar?					ath (Check only one	9)					
	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat		Itient 3LI DUA		lome 5 Reside						
edical Certification: 10	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28e. Dete of Inj (Month, D	ury 28b. Tim ay Year) lnju	ry V		28d. Describe ho	w Injury occur	red				
	2 Accident investigation		4		Yes 2 No	206 2001/27 (0)	root and there	nor or Pum I Park	Alumbas			
	4 Homicide determined	ZBA PIACA OF ID	ijury - At home, farm tc. <i>(Specify)</i>	, street, factory, offic	> 0	28f. Location (Str City or Town	, State)	ber or Rural Route	ryumber,			
	29a. Certifier 1 Cartifying Phy	velcian: To the heet	of my knowledge d	eath occurred at the	time, date end place	and due to the co	use(s) and m	enner as stated				
1	(Check only one)	inar: On the basis of end menners	of examinetion and/o	r Investigetion, in my	y opinion, death occu	rred at the time, de	ete end place,	end due to the ca	use(s)			
	29b. Signature and title of certifier			29c. Lice	ense number	29	d. Date signe	d (Month, Day, Y	ear)			
	MAG	-	m.D	Do	50678		1/26	100				
3	30. Neme end address of person who	completed cause of	deeth (ttem 23e) (Ty	pe, Print)			100					
	Rajeev Batra, MD	10801 L	ockwood	Drive, #3	325 Silve	r Spring,	MD	20901				
te	31. Date filed (Month, Day, Year)	32 Regist	trar's Signeture	1		, =						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg. No.	04012						
81 11	1. Decedent's Name (First, Middle, Last)			1	2. Date of Death Month Day	3. Time of Deeth						
Physician /Medical	Henry A. Straney			J	anuary 26, 20							
Examiner	4a Facility Name (If not institution, give street and	number)	Set of the	4b. City, Town, or Loca	ation of Death 4c. County							
Funeral Director	SHADY GROVE ADVEN 5. Social Security Number 367-03-1139 6. Sex 1 № 42□	7. Age (In yrs. last bi			3. Date of Birth (Month, Day, Year)	TGOMERY 9. Birthplace (State or Foreign Country) Michigan						
	Usuat Residence of Decedent	40- Ch. T.										
da f	10a. Stata 10b. County	10c. City, Tow	vn or Location		10d. Inside							
cto dia	Maryland Montgomery	Rockv	ille			1 X Yes 2 □ No						
miner must be notified at Funeral Director	10e. Street and Number 317 Broadwood Drive		10f. Zip Code 20851		10g. Citizen of V	What Country? States						
5	11. Maritai Status 1 □ Never Married 2 ☑ Merried 3 □ Widowed 4 □ Divorced 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☑ Yes 2 □ No WWII 1 Yes, Give Yaar or Datas:		13. Was Decedent of h	an, Mexican, Puerto R	ity Yes or No- 14. Race	s - American Indian, k, White, etc.						
ted	15. Decedent's Education		. Decedent's Usual Occup	pation	16b. Kind of Bu	siness/Industry						
Completed	(Specify only highast grada completed the Elementary/Secondary (0-12) College 2	e (1-4or 5+)	(Give kind of work done life. DO NOT use retired ob Evaluato)		100	Government						
	17. Father's Name (First, Middla, Last)		ob Evaluator.		First, Middle, Maiden Surnam							
Be	John Straney			Eldeshoot	. 17							
6	19e. Intorment's Name/Retationship (Type, Print)	401	h 14-16 Add (Ot	Elizabeth	1 Ferns Route Number, City or Town,	Otata Via Cadal						
	and the fact that the same of											
	Louise Lamm Straney/Wi 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal tr 4 □ Donation 5 □ Other (Specify)	Rockville, Maryland 20851 Date 29. 20c. Location - City or Town, State 29. Rockville, Maryland										
	21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850–280											
at er	Immediate Cause (Final disease or condition resulting In death) a	Due to (or as a	CANCET consequence of):			Intervel Between Onset and Death						
VMedical Examiner	Cause (bisease or injury that initiated events resulting in death) Last Dua to (or as a consequence of):											
Physician/	Part II. Other aignificant conditions contributing t	ven in Part I.	23b. Did tobecco use contribute to the cause of death?									
by Ph					1⊉Yes 2□ No	3 Probably 4 Unknow						
Completed I					24a. Was an autopsy performed?	24b. Were autopsy tindings available prior to completion of cause of death?						
5					1 ☐ Yes 2 ☐kNo	1 ☐ Yes 2 ☐ No						
Be	25. Was case reterred to medicat			26. Place of Death	(Check only one)							
.0	axaminer? 1 Yes 2 No Hospitat:	☑Inpatient 2□ER/O	utpatient 3 DOA Oth	ner: 4 Nursing Hom	e 5 Residence 6 Oth	er (Specify)						
ation:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pl	fonth, Day Year)	Time of injury M 28c. Injury Wo 1 □	Yes 2 □ No	d. Describe how injury occurs It. Location (Street and Numb City or Town, State)							
edical Ce	29e. Certifier (Check only 2 □ Madical Examinar: On the											
Medical Certific	one) and n 29b. Signature and titte of certitier	se number	29d Date sinne	d (Month, Day, Year)								
	Solution and title of certifier	14157		y 36,2000								
1	30. Name and address of person who completed of IRR BERGER M.D. SC	ause of death (Item 23a)	(Type, Print)	wckille,	maryland							
State gistrar	31. Data filed (Month, Day, Year) FEB 1 2000	2. Begistrar's Signeture	5. South									



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Type of Philit in black indelible link. Assure All Copies Are L			
State of Maryland / Department of Health and Mental Hygiene	00	046	13
Certificate of Death Reg. No.			

Physician /Medical Examiner

Director

Funeral

þ

Completed

Be

4a Facility Nama (If not institution, give street and number)

Suarez

1. Decedent's Name (First, Middla, Last)

4b. City, Town, or Location of Death

3. Time of Death January 31, 2000 2:34 am

Holy Cross Hospital 5. Social Security Number 6. Sex 1 M 2 F

Silver Spring | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Nov 18, 1932 7. Age (In yrs. last birthday)

Montgomery Birthplace (Stata or Foreign Country)
 Cuba

4c. County of Death

Funeral Director

28a-f g

must be

filed within 72 hours after

Hygiene.

Pages 1 and 2 should be fill iment of Health and Mental H-bant: If Nem 27 is marked oth lury or other traumstic even

Physician /Medical

Examiner

ician and burial-transit

the

US0 88 1

signed by the atte

page 2

certificate

this funeral

After !

death.

24 hours after deat Funeral Director:

within 2 the th

Hospital

2

filled in by

completely

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital or Attanding Physician: Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

Baltimore, Maryland 21215-0020

Usual Rasidenca of Decedent 10a. Stata 10b County 10c City Town or Location

10d. Inside City Limits

Maryland Montgomery 10e. Street and Number

579-02-5434

67

Silver Spring

10f. Zip Code 10g. Citizen of What Country? USA

2. Data of Death

Month

1 Vas 2 No

10120 New Hampshire Ave. Apt 103 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas:

20903 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.)

11. Marital Status

Pedro

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

1 Yas 2□ No

Cuban

18 Mother's Name (First Middle Maiden Sumama)

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedant's Education (Specify only highast grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

8 17. Fathar's Nema (First, Middle, Last) Construction Worker

Construction

Antero Suarez

Caridad Unknown

Specify:

19a. Informant's Name/Reletionship (Type, Print)

5913 Cherrywood Lane Apt 303, Greenbelt, MD 20770

Yaseel Suarez/ Daughter

20b. Place of Disposition (Name of cematary, crematory or other place)

20c. Location - City or Town, Stata 2/3/00 Silver Spring, MD

20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify)

21. Signature of Funeral Service Licensee

Gate of Heaven Cemetery

22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

ceri nu 23a. Part1. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

500 University Blvd., W, Silver Spring, MD 20901 Approximata Interval Between Onset and Death

Immediete Cause (Final

. Arrythmia

Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuss given in Part I.

Dua to (or as a consequence of):

disaase or condition rasulting in death)

Cardiomyopathy

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaese or Injury that initiated evants rasulting in death) Last

Congestive Heart Failure

Dua to (or as a consequence of):

Respiratory insufficiency & Hypoxia

> 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown

Coronary Artery Disease

Diabetes Mellitus

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

1 ☐ Yes 2 X No

25. Was casa rafarred to medical axaminar? 1 Yas 2 No

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 5 Panding invastigation 2 ☐ Accident

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28b. Tima of 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yas 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

1 Netural

3 ☐ Sulcida

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signatura and titla of certified

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

53601

29d. Data signed (Month, Day, Year) January 31, 2000

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

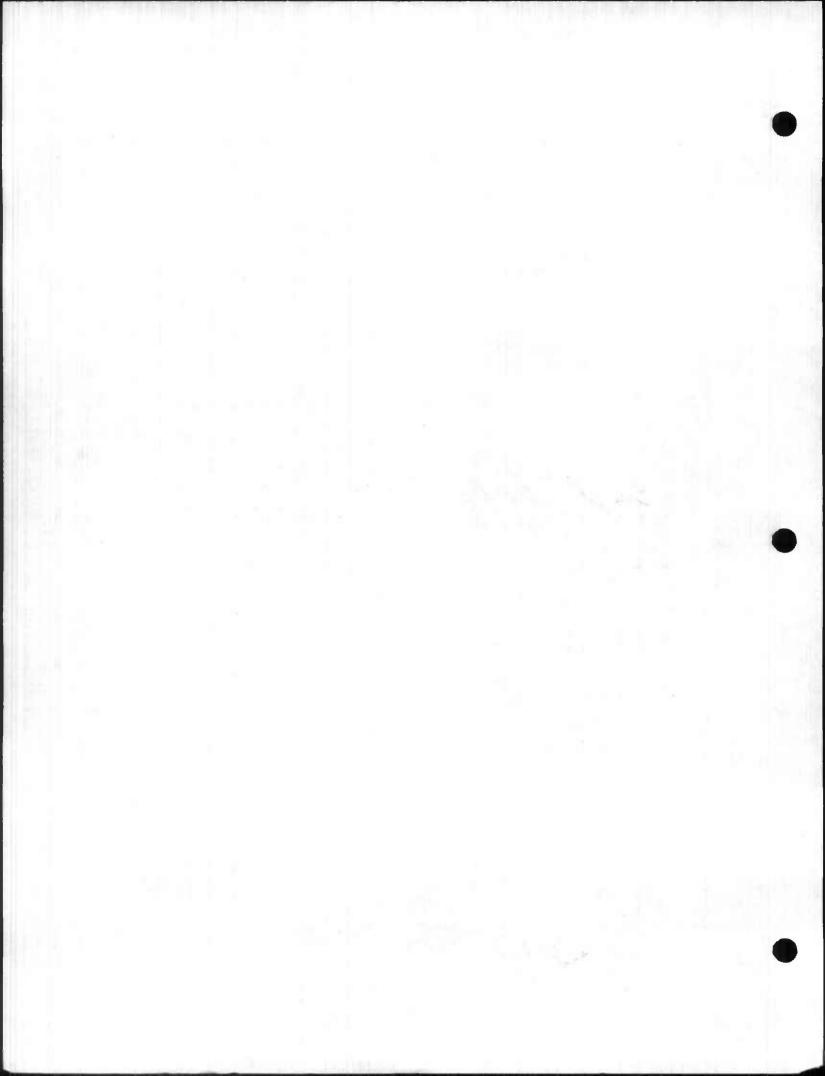
11119 Rockville Pike#100, Rockville, MD Pankaj Lal, MD

State Registrar

31. Data filed (Month, Day, Year) 2000

6 Could not be

Pegistrar's Signature

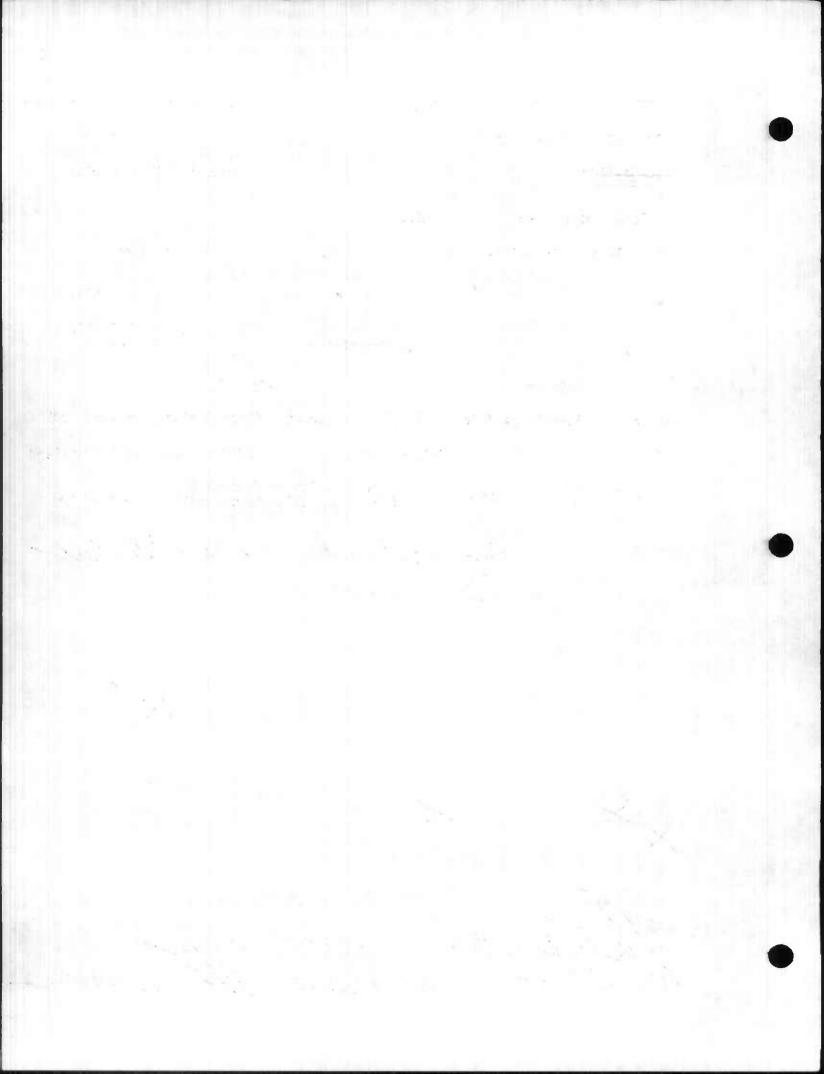


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** MARY SUDDATH JANUARY 30 2000 12:39 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 F Yrs. 85 Dec. 16,1914 Director 216-44-6743 Maryland Usual Residence of Decedent tha Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Olnev 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 5510 Olney-Laytonsville Road 20832 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 M No Specify: White Specify: À 3 ₩idowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry
National Institute 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade complated) Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) of Health Lab Technician 12 7 is marked other traumatic event, marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Be Nettie E. John Leizear Groomes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 12710 Laux Street, Silver Spring, Maryland 20904 Thomas J. Finneyfrock / Son 20b. Piece of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ery, crematory or other place) 1

Buriai 2 □ Cremation 3 □ Removal from State Salem Cemetery 2/3/00 Brookeville, Maryland Department 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038. Laytonsville, Maryland 20882 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Burys A, Heile, Halan /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es e consequença of) Examiner POR18 that the death certificate be axecuted physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of): attending pt signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yss by 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy certificata has lirector, paga 2 s 1 Yes 2 No 1 Yes 2 Attending Physician: director, Be 25. Was case referred to medical examiner? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2RER/Outpatient 3 DOA this funaral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Aftar Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after deat Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 3 4 Homicide hours Hospital edical 29a, Certifier stifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated. pletely dical Examiner: On the besis of examination and/or investigetion, in my opinion, death occurred et the time, date and piece, and due to the cause(s) 8 within To the å 29c. Licensa numbe And Date signed Worth, Dev. Year) 20

State Registrar 31. Date filed (Month, Dey,

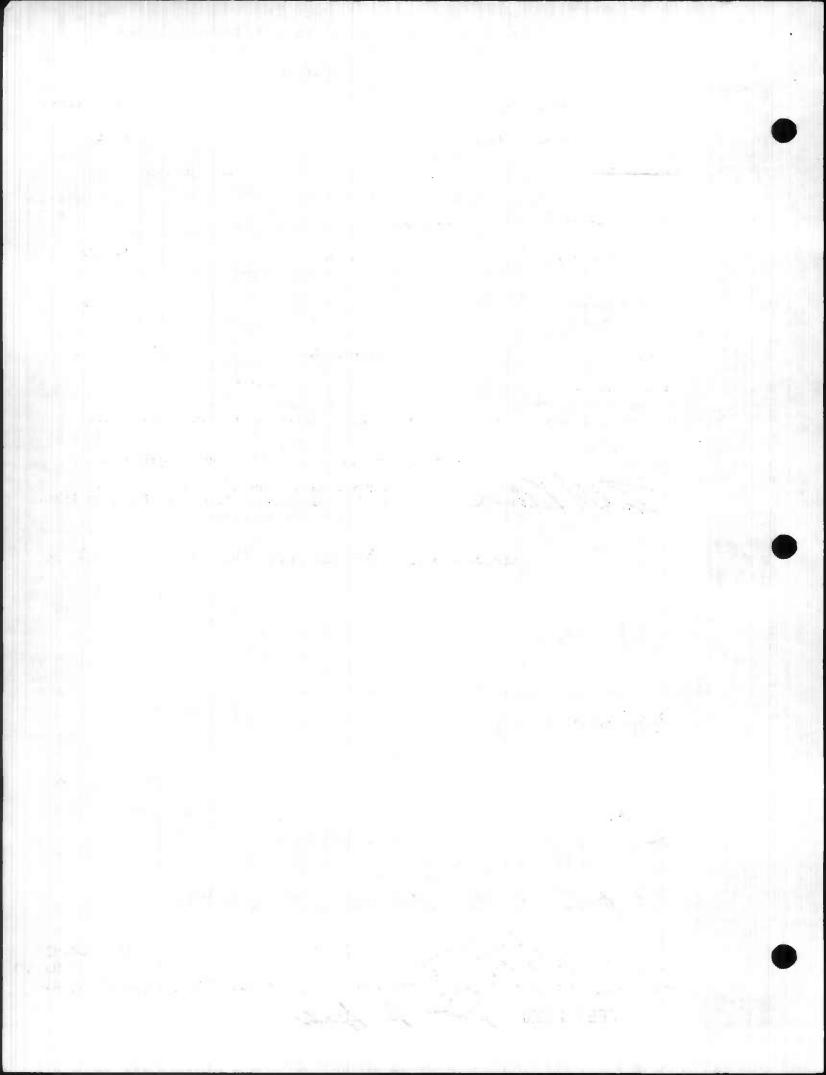
FEB 03 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #5, Per F.D. 2/7/00, Carroll County, wjl Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Deeth **Physician** 3 Pey 12:20 AM Ruth Dolores Stewart 2000 Jan /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Lutheran Village Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthdey) 5. Sports Sequer 14752 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1 M 2 X F Yrs. 78 174 14 1752 Dec. 20, **Director** Usual Residence of Decedent with the Meryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll 1 ☐ Yes 2 🖾 No Directo Westminster 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code Examiner must be 205 St. Mark Way United States permit. Pages 1 and 2 should be filed within 72 hours effer death v. Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a ents Injury or other traumatic event, the Medical Examiner reservences. 21158 Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritai Stetus 1 ☐ Yes 2 🕏 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Electronics Line Supervisor 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Della Kradel Wilmer Osborn 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1617 Valley Drive Westminster, MD Richard J. Stewart Son 20b. Piace of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 2/4/2000 Hampstead, MD 22. Name and Address of Facility
Burrier-Queen Funeral Directors, P.A. 21. Signature of Funaçal Service La eno 1212 W. Old Liberty Road Winfield, MD 21784 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Cause (Finel disease or condition resulting in death) /Medical End Secus Abrhemers Demuto 2 Examiner Due to (or es consequence of) Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as e consequenca of): attending p 65 65 ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 22 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certilicate has b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 20 No or Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 251 No this funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 Natural s after dee. 1 Yes 2 No in 24 hours
the Funeral Director
the funeral Direct 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) JE Certifying Physician: To the bear of my knowledge waith occurred et the time, date end piece, end due to the ceuse(s) end menner as stated.

For investigation, in my opinion, death occurred et the time, dete and piece, end due to the cause(s) 29a. Certifier edical To the Hosp within 24 ho To the Fune completely fi (Check only one) On the basis of exer and mayber stated. 29b. Signature and title of certifie 29d. Date signed (Month, Dey, Year) 29c. License number Jan 315 2000 123 revea 30. Name and eddress of percent who complete of deeth (item 23q) (Type, Print) 295 Semen Bure Sut 307, upscult Mx and 31. Date filed (Month, Dey, Year) FEB 0 1 2000 Registrar

DHMH 16 Rav 6/95



State Registrar

/Check only onel

29b. Signeture and title of certifier

Kat

RAKESH ARORA, MO 31. Date filed (Month, Day, Year)

FEB 1 4 2000

DHMH 16 Rev 6/95

Box 68760.

P.O.

Records,

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32: Registrar's Signeture

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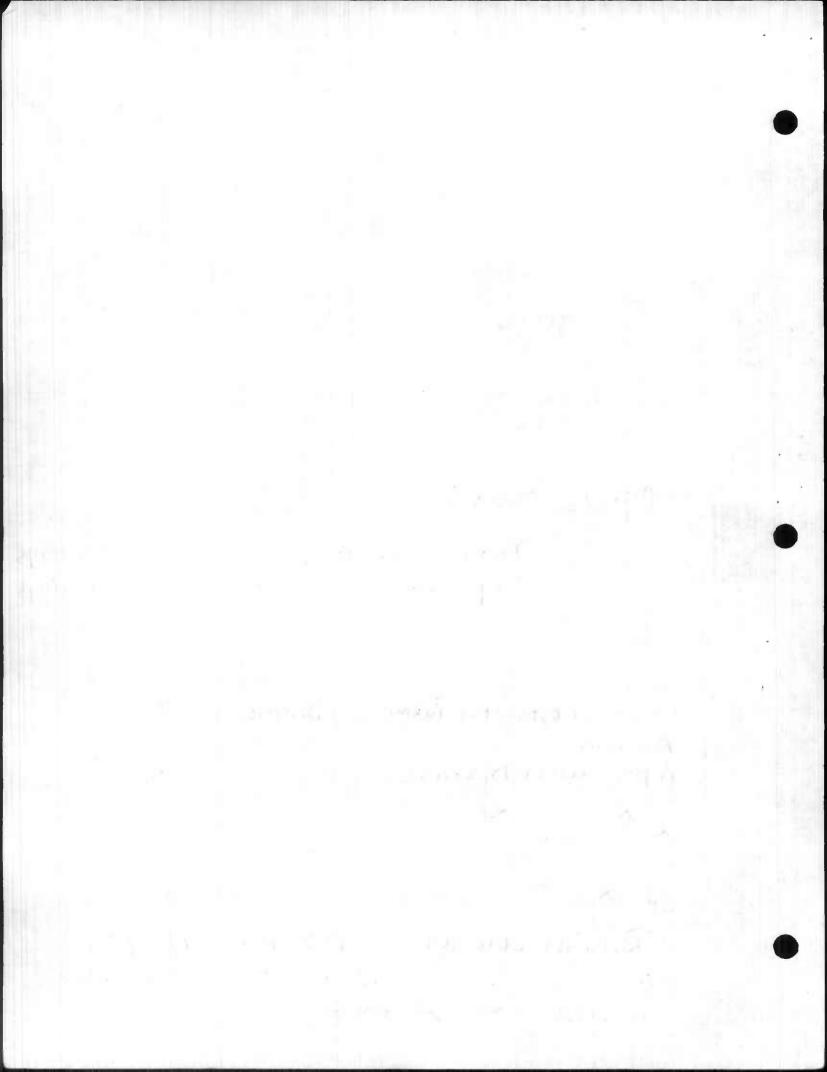
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D20108

29d. Dete signed (Month, Day, Year)

FOX LANE, SUITE 222, BOWE, MD 20715



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) 04617 Certificate of Death Amended item# 17, FCHD, KS 1/31/00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 18, 2000 Charles Joseph Shafer 8:14pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3394 Red Oak Court Frederick Middletown 8. Date of Birth (Month, Day, Year) 6. 1927 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1K) M 2 T F MD. 213-24-9691 72 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Wedges Examiner must be notified at MD. Frederick Middletown 1 Yes 2 □ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 204 W. Main St. 21769 U.S.A. Funerai death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer of ment of Heelih and Mertal hygiene.
ant: if farm 27 is marked other than "natural", or flee into yor other traumals event, the Medical Emericany or other traumals event, the Medical Emericans 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Baitimore, Maryland 21215-0020 1 Yes 2K No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) heavy equipment operator federal gov't. 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Hoseph Edward Shafer Joseph Edward Shafer Effie Virginia Wiles 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June T. Shafer (Wife) 204 W. Main St., Middletown, MD. 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department of Important: If eny Injury or pose. Lutheran Cemetery 1/21 Middletown, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donald B. Thompson Funeral Home 21. Signature of Funeral Service La 31 E. Main St., Middletown, MD. 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only crimically on each line. 23a. Part T. Enter the di Approximata Interval Between Onaet and Death Physician /Medical Immediate Cause (Finel Arteriosclerotic Cardiovascular Disease Years disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 980 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? page 2 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital at or Attending Physician: T s efter death. I Director: After this certificat ed in by the funeral director, pr 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) \forall Work site 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Di Natural 1 □ Yea 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, atreet, tectory, office building, etc. (Specify) An 24 hour.

Funeral Dire.

filled in by 4 Homicide Hospital edical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated. To the Hosp within 24 hou To the Funa completely fi

State Registra

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registra/s Signature 7 2000

30. Neme and address of person who completed called the (Nem 23a) (Type, Print)

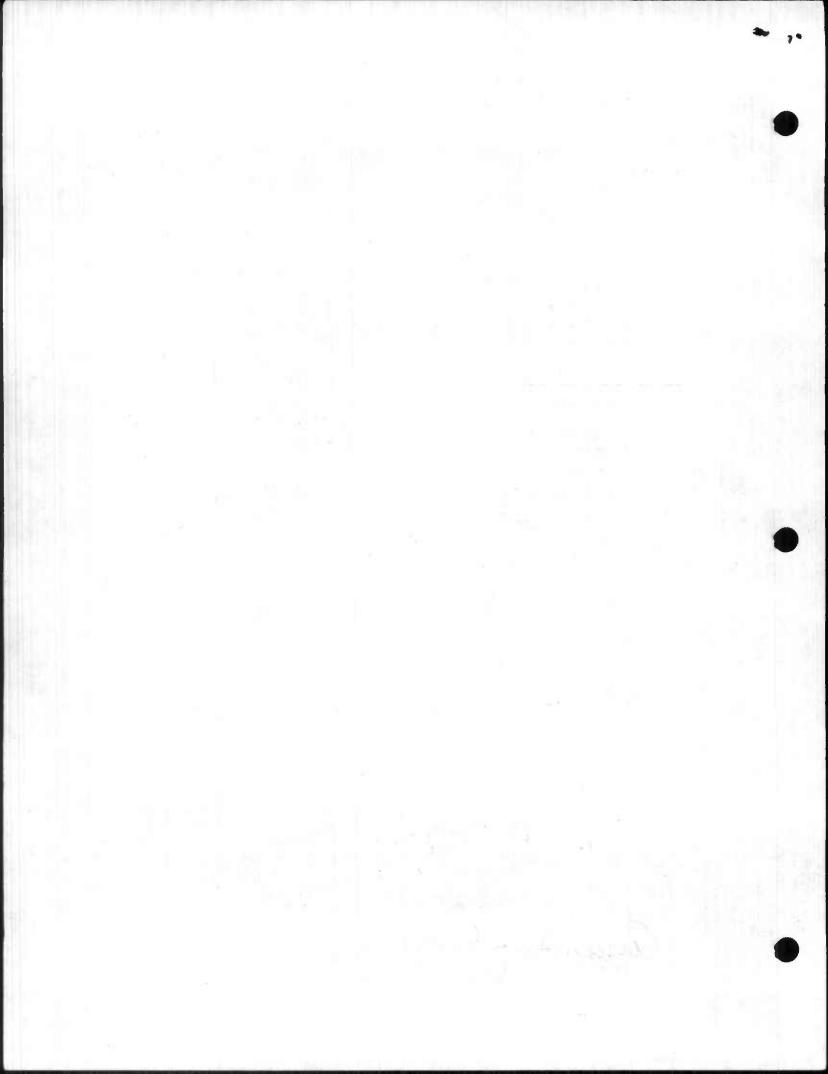
Andrew Zarick, Jr, M.D, 1030 West Patrick Street, Frederick, Maryland 21703

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29c. License number D35164

29d. Date signed (Month, Day, Year)

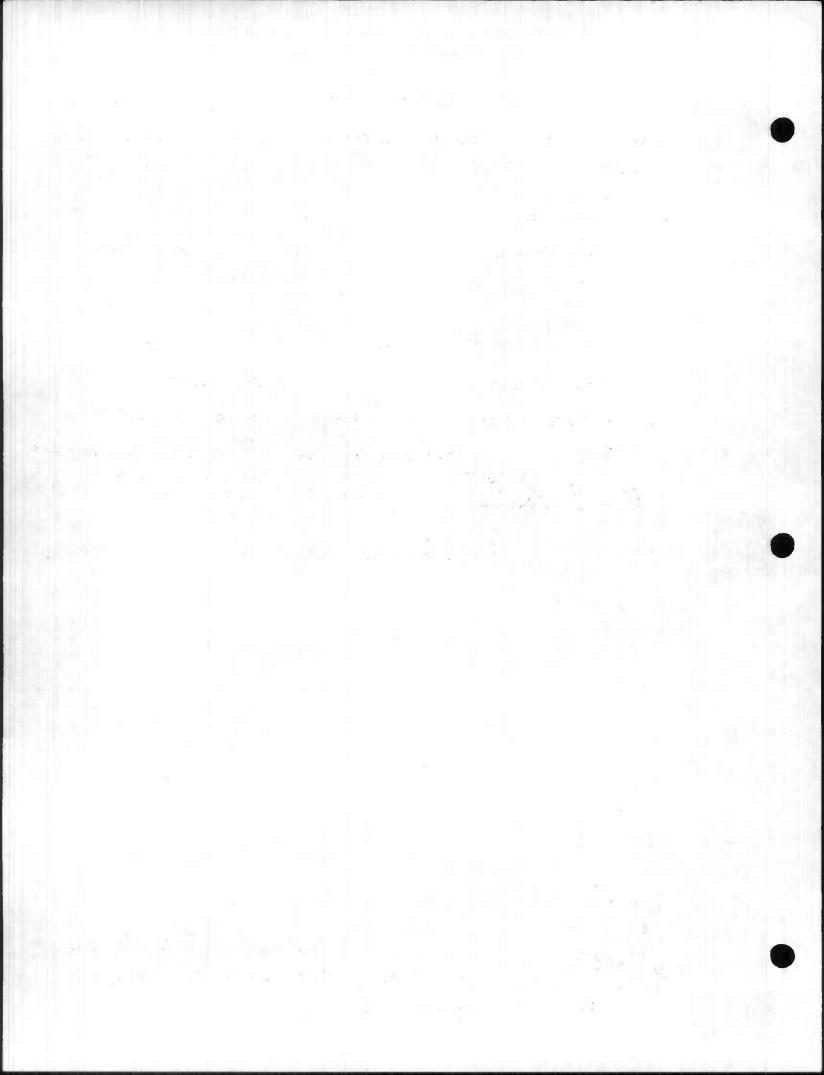
January 19, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 4 6 8

				Certificate of Death Reg. No.												
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Baltimore,				Cremation 3	Removal from St	20b. Place of Disposition (Name of cemetery comparatory or other place) PESD 1 20c. L						20c. Location Smithsk			and	
Balti	permit. Pages Departmant of Important: If I any Injury or once.	21. Signature of Funeral Service Licensee / MO1072 22. Name and Address of Fecility Skiles Fune:												neral Home Taneytown, MD 21787		
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	To the Hospital or Attervision 24 hours after de To the Funeral Directo completaly filled in by the standard of the standard o				nyeician: To the bas and manne	is of examina)
	To the round of th	29b. Signature and title of certifier 29c. License number 29d. Dete signed (i									ed (Month	, Dey, Year)				
			De 1. 1	C-3					D	265	25		FEB		200	0
			30. Name and a state	of person who	completed cause	of death (Ite	m 23a) (Typ	e, Print)	1	DIK.	G	200 10	0)	120	7	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death January 25,2000 Yaar 12:27pm Emil Edgar Shober 4b. City, Town, or Location of Death 4a Facility Name (ff not institution, give street and number) 4c. County of Deeth Frederick Memorial Hospital Frederick Frederick If Undar 1 Yeer | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug. 13, 1 5. Sociel Security Number 217–12–2851 7. Aga (In yrs. last birthday) 77 Yrs. 6. Sex Birthplaca (Stata or Foraign Country) Days 10XM 2□ F Months Hours 1922 Pennsylvania Usual Rasidence of Decedent 10b. County Frederick 10c. City, Town or Location Frederick 10a. Stata 10d. fnsida City Limits Maryland Was 2□No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 629 Wilson Place 21702 U.S.A. 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give* Yaar or Datas: 11. Merital Status Was Decedant of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14 Bace - American Indian Black, Whita, alc. 1 ☐ Nevar Married 2 X Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Data Processing Insurance 18. Mothar's Neme (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middle, Last) Ralph Shober Mary 19a. Informant's Name/Ratationship (Type, Print) 19b. Melling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. Florence Shober, wife 629 Wilson Place, Frederick, Maryland 21702 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 🛱 Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Othar (Specify) Mount Olivet Cemetery, Jan. 29, 2000 Frederick, Maryland 21. Signature of Funaral Service Licenşee 22. Nama and Address of Facility Keeney and Basford PA Funeral Home Richard MO0255 106 East Church St., Frederick, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiec or respiratory arrast, shock, or heert failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediate Causa (Finat disaasa or condition rasulting in death) en mits Due to (or es e consequença of) Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated experts.) that initiated events rasulting in death) Last Due to (or es a consequance of): Part II. Other significant conditions contributing to death but not rasulting in tha undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyas 2 No 1 Yes 2 No 25. Was casa refarred to medical 26. Placa of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yas 2 No 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Natural

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 page 2 should be this certificate has applate or Attending Physicien: Thours after death.
Inexel Director: After this certificate filled in by the funeral director, pa

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

28a-f

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Name 23a

b

72 hours after

should be filed within al Hygiene.

Pages 1 and 2

Mental marked

of Health Nem 27

Department Important: any injury once.

Physician

/Medical

Examiner

6 ò

21215-0020

Maryland

Baltimore,

event, the Medical Examiner must be notified

Physician/Medical Examiner ģ Be Completed Medical Certification: To

3 Suicide

29e. Certifier

4 Homicide

5 Pending 2 Accident 6 Could not be detarmined

invastigation 28e. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

MA

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

12 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete and placa, end dua to the ceuse(s) and mennar as stated.
2 Medicat Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, data end place, end due to the cause(s) and mannar stated. 29b. Signature and IIII

29c. Licensa number 0018063 29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

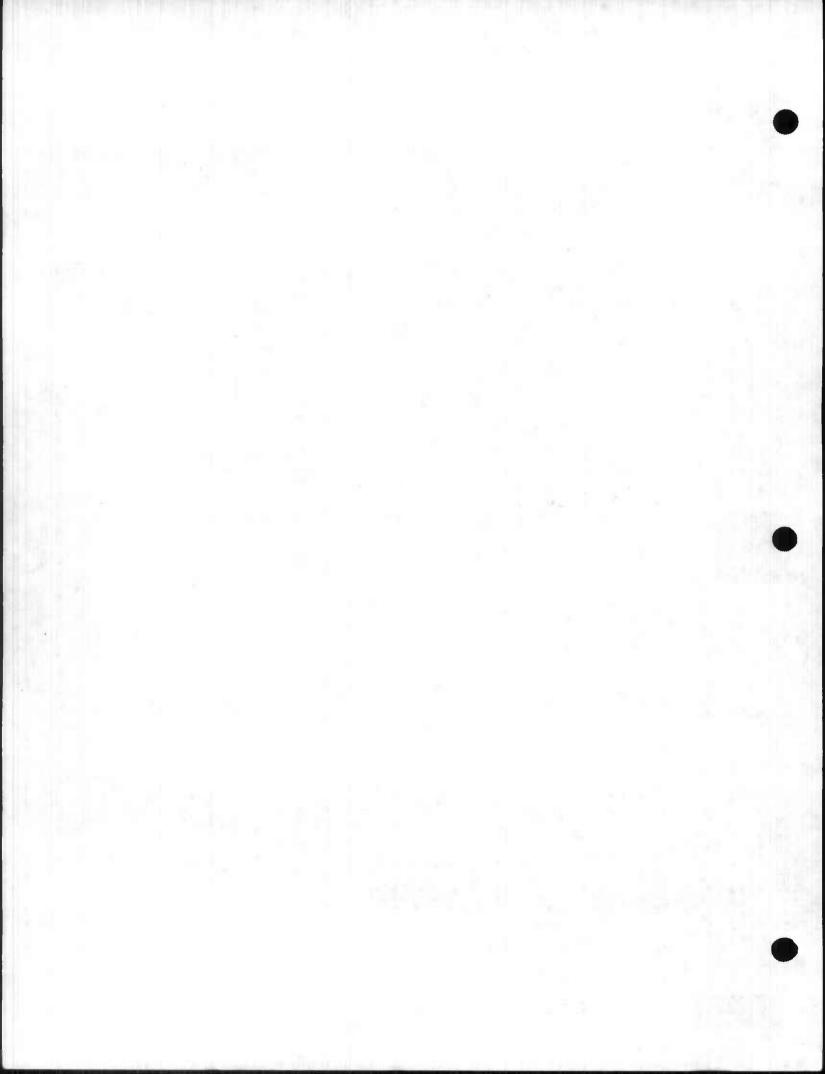
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State Registrar

DHMH 16 Rev 6/95

To the Hospital of within 24 hours a To the Funeral D



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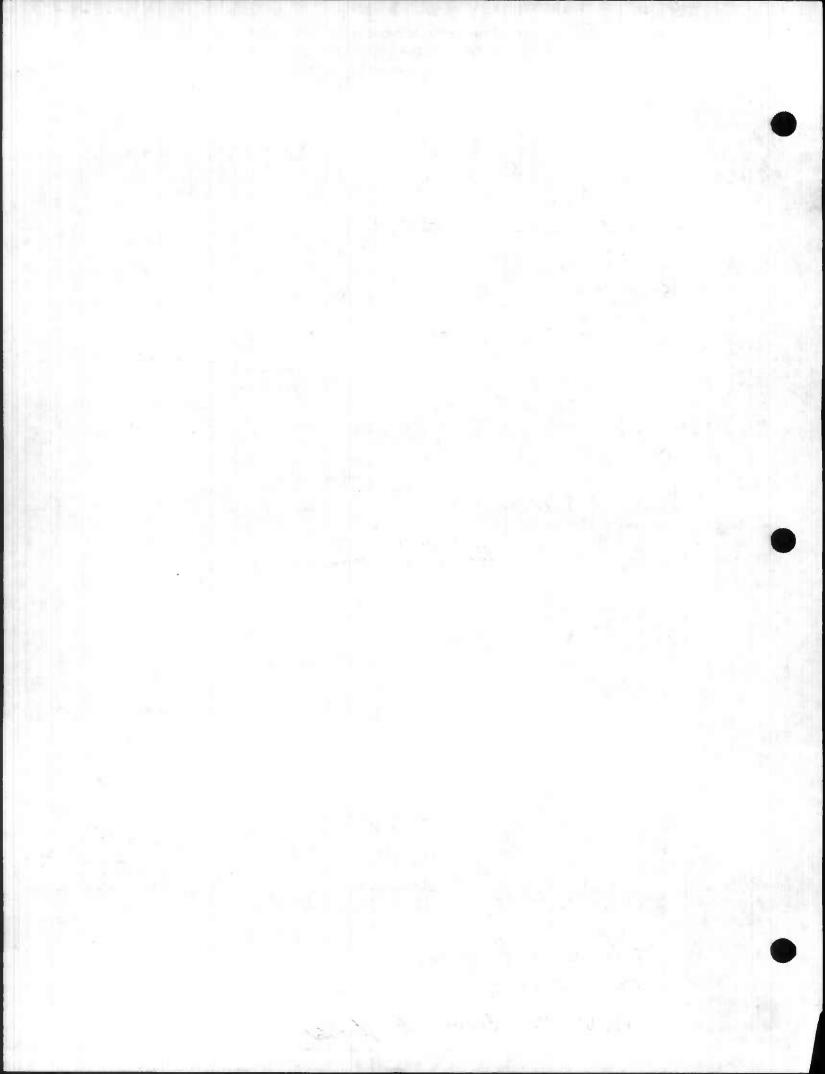
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State Registrar 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201

ORIGINAL

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 04621 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:40 AM 23,2000 ELIZABETH CAREY THOMAS JAN. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner SALISBURY CENTER: GENESIS ELDERCARE SALISBURY, MD. WICOMICO 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 🗓 F Yrs. 221-24-9039 Director 88 06-01-1911 MARYLAND Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Directo DELAWARE SUSSEX FRANKFORD 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 238 U.S.A. **#10 CLAYTON AVENUE** 19945 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Meritel Stefus Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 21215-0020 ò 1 Yes 2 No Specify: Specify. à 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Nem 27 is merked other than "e ury or other traumetic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) STORE OWNER 12 GROCERIES Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be HORACE CAREY SARAH DONAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD#1 BOX 24A, FRANKFORD, DELAWARE. 19945 WILLIAM L. THOMAS/ SON laltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata Department of h Important: If Ites any Injury or off 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from Stele DAGSBORO REDMENS MEM. CEM. 01-27-00 DAGSBORO, DELAWARE 4 Donation 5 Other (Specify) 22. Name end Address of Facility MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 23a. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician Immediete Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): CO The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lesf Due to (or es a consequenca of) P.O. Box 68760. 20,1 en Physician/Medicai the Due to (or as e consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? hed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were autopsy tindings evailable prior to completion of cause of death? Be Completed 24e. Was an autopsy 1□ Yes 2□No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Affer 1 Natural 5 Pending efter deeth. 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, streef, fectory, office building, etc. (Specify) filled in by 4 Homlcide 8 24 hours e Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) To the To the To the 29b. Signeture and title of cartified 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

WILLIAM ROBINS, M.D. 31. Dete filed (Month, Day, Year) FEB 0 2 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

1104 HEALTHWAY DR., SALISBURY, MD. 21804

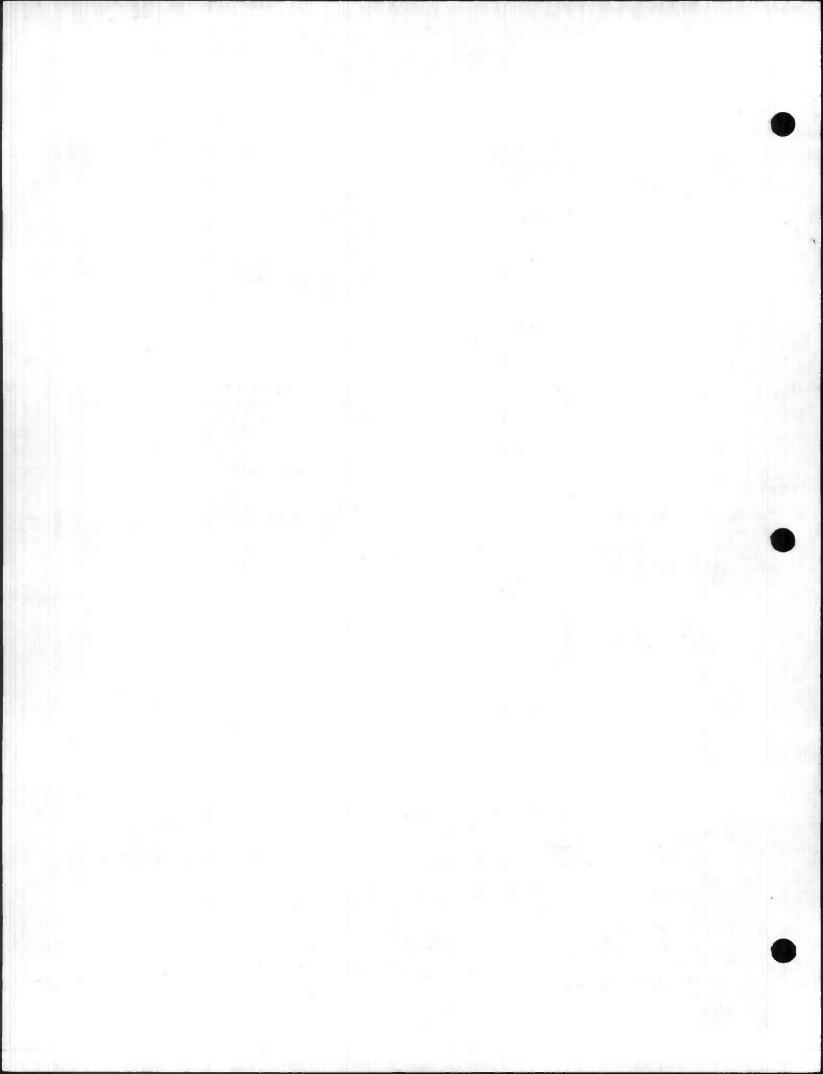
22. Registrar's Signature

FEB 02 2000 James 10 James

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nysician		23a. Part 1. Enterth shock, or hear	t failure. Lis	t only one ceuse	on each I	ine.	DO HOL GITE	or tria mode or	Gy III	ig, such es card	ac or respiratory	errest,		interv	el Between and Death
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in by the		2 Accident 3 Suicida 4 Homicide	6 Could deterr	nined 200.		jury - At hon ic. (Specify)		et, factory, off		169 Z L NO	281. Location City or T	(Street and own, Stete)	Number	or Rural Route	Number,
within 24 hours after death. To the Funeral Director: A completely filled in by the funeral Medical Certification.		29a. Certifier (Check only one)	Cortifyi	Examiner: On t	o the best the basis of manner st	of examinetic	ledge, death on end/or inv	occurred et th	e tim	ne, date end pla pinion, death oc	ce, end due to the	e cause(s) a e, date end p	and menn- plece, and	er es stated. I due to the ce	ouse(s)
omple of Me		29b. Signeture	the of certific	- 11	aminer St		,	29c. Lic	ens	e number		29d. Date	signed (#	Month, Dey, Y	ear)
2		30. Neme and addre	M	2014	4	M	. 0	1.	0	46364	7	7.1			
	1	su. Neme and addre	pss of person	who completed	cause of	D/K	23e) (Type, I	Print) SOX	-00	2527	MALLER	11.0	MI	206	25-

State Registrar 31. Dete filed (Month, Dey, Year)
JAN 3 1 2000

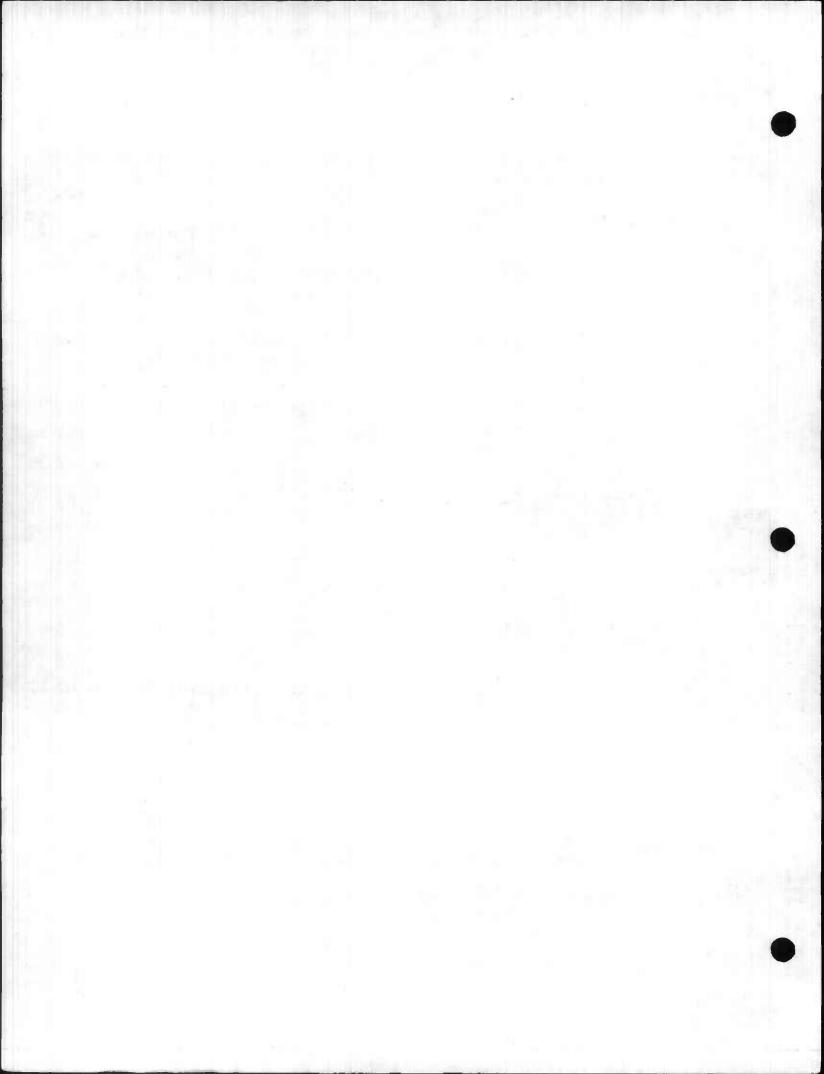
32. Begistrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 04623 Certificate of Death 1. Decedeni's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death TAYLOR **Physician** E DMOND January 27, 2000 3:00 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery # Under 1 Veer 5. Social Security Number If Under 24 Hrs. 8. Dala of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours 1 XM 2□ F Yes 85 Jan. 9, 1915 Director 181-10-2449 Pennsylvania Usual Residence of Decedent r than "natural", or flama 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Bethesda Maryland | Montgomery 10a. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 9301 Ewing Drive 20817 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Haalth and Mentai Hyglene. Important: If item 27 is marked other than "natural", or her any injury or other traumetic svent, the Medical Exemples once. 1 ⊠ Yas 2 □ No If Yes, Give Yaar or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: ð 3 ☐ Widowed 4 ☐ Divorced WW II White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be Elias Daniel Taylor Genevive Catherine McKinley 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Evelyn E. Taylor/Wife 9301 Ewing Drive, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 4, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 2000 Cheltenham, Maryland 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Ligensee M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haan failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 158 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 5 1 ☐ Yes 28 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1-3 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident hours after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 | Homicide Hospital or within 24 hours a To the Funeral Completely filled 29a. Certifier Text Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and mannar stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 50+1 ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a BETHESDA, MO 20814 4930 RVING MO MIZU DEL 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death JUNE WATERMAN TAYLOR January 23, 2000 23:40 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOME RY If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days 1□M 2√2F Yrs. 218-34-5147 Dec. 2, 1905 Vermont Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Florida Collier Naples 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? 813 Central Avenue 34102 U.S.A. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify. 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Stephen Waterman Gertrude Pope Whittier 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon G. Taylor (Son) 225 Susquehanna Trail, Winchester, VA 22602

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriet 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donellon 5 ☐ Other (Specify) Cremation Center 1/26/00 Chantilly, VA 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Murphy's Falls Church Funeral Hom Burse mallen 1102 W. Broad St., Falls Church, VA 22046 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Intervet Between Onset and Death Immediate Cause (Finei disease or condition resulting in death) MEARS Due to (or es a consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospitet: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Physician /Medical Examiner

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29e. Certifier

that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital or Attending Physicien: **Physician**

/Medical

Examiner

Funeral

Director

Show

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permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if Item 27 Ie marked other than "natural", or itema 23a or eny Injury or other treumatic event, the Medical Examiner must be.

Maryland 21215-0020

altimore,

notified at

Director

Funeral

by

Completed

Be 2 12

Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Physician/Medical

NEUMONIA

25. Wes case referred to medical 1 ¥ Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending

28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 Accident investigetion 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

McCertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and menner es stated.

| Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signeture end title of certifier

29c. License number 29d. Date signed (Month, Day, Year) B30692

JANUARY 24, 2000

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

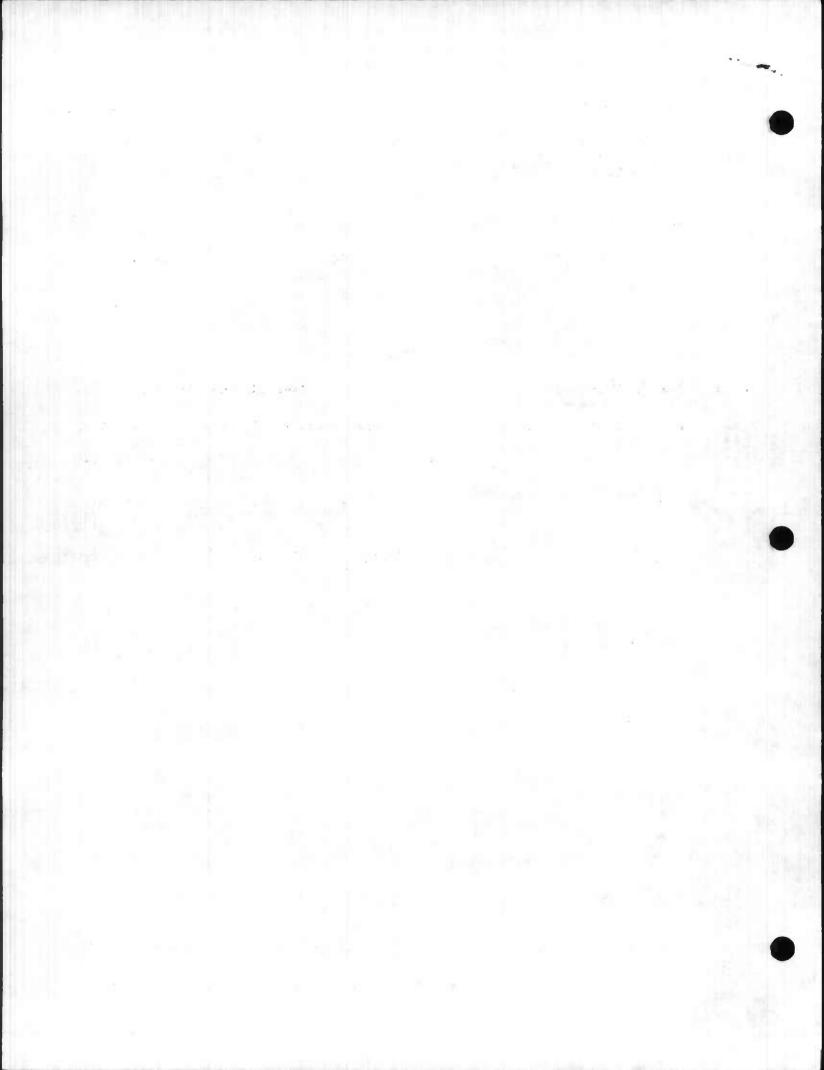
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15225 Shady Grove Road, #305, Rockville, MD 20850

1 ☐ Yes 2 ☐ No

State Registrar

31. Dete fire (Month, Day, Berreby JAN 3 1 2000

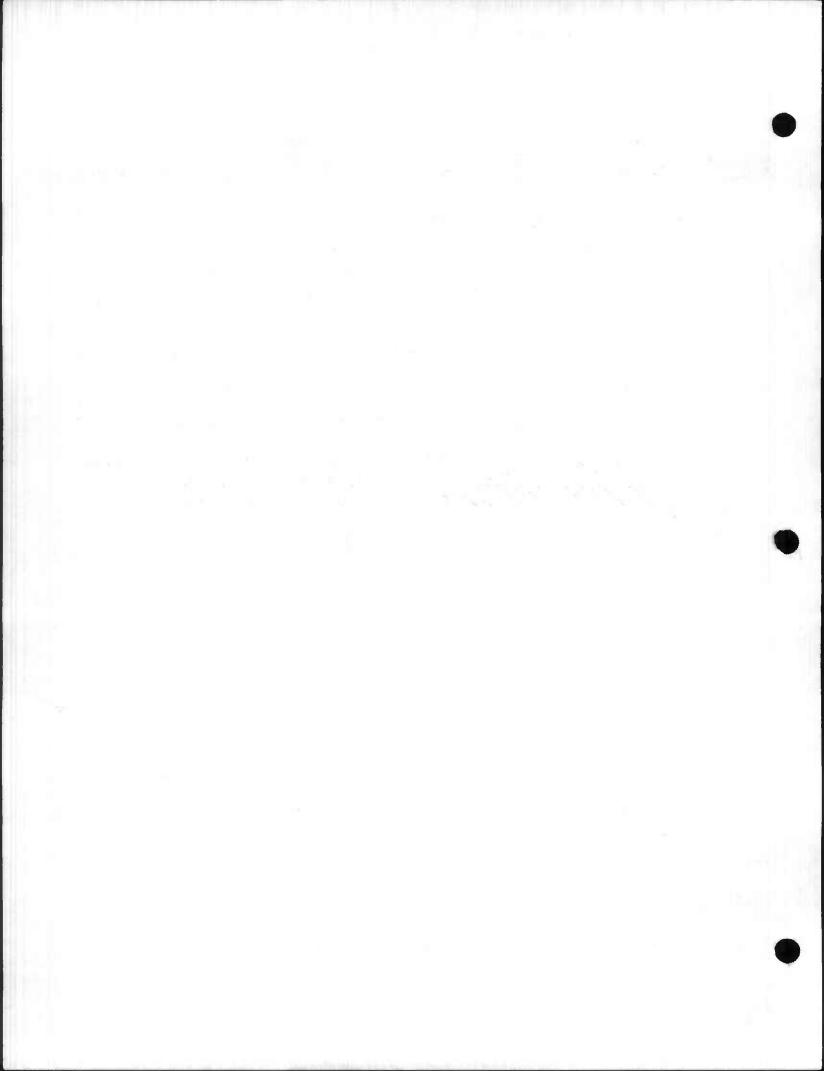


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State of Maryland / Department of Health and Mental Hygiene 0 0 4 6 2 5

							Ce	rtificate	of	Death		Reg. No.		14020	
П	Physic	lan	1. Decedent's Name								2. Date of D Month	eeth Day	Year	3. Time of Death	
	/Medi		Eula S:	imms Tri	gg						Januar			10:30 PM	
	Exami	ner	4a. Facility Name (II			mber)				4b. City, Town, or l	ocation of Dea	ith 4c. Coun	ty of Deeth		
L	70.1			r Health	Care					Bethesd					
	Funeral		5. Social Security N		Sex 1□M X □F	7. Age (In yrs.		If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth lay, Year)	9. Birth	place (State or Foreign	
	Director		578-62-22	221		9.	5 Yrs.				July 2	ly 24,1904 Washington			
	and *-		Usual Residence of 10a. State	10b. County		10c. Cit	tv. Town or Lo	ocation						10d. Inside City Limits	
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Division	or Attend after death Director: / d in by the f	Certification:	4 ☐ Homicide	determined		of Injury - At hong, etc. (Specif		eet, ractory, o	опісе		28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
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	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical		Medical Exar	ninar: On the bi	asis of exemina	medge, deeth tion and/or In	vestigation, in	my o	me, date and place, plinion, death occur	red et the time	, date and place	, and due t	tated. o the cause(s)	
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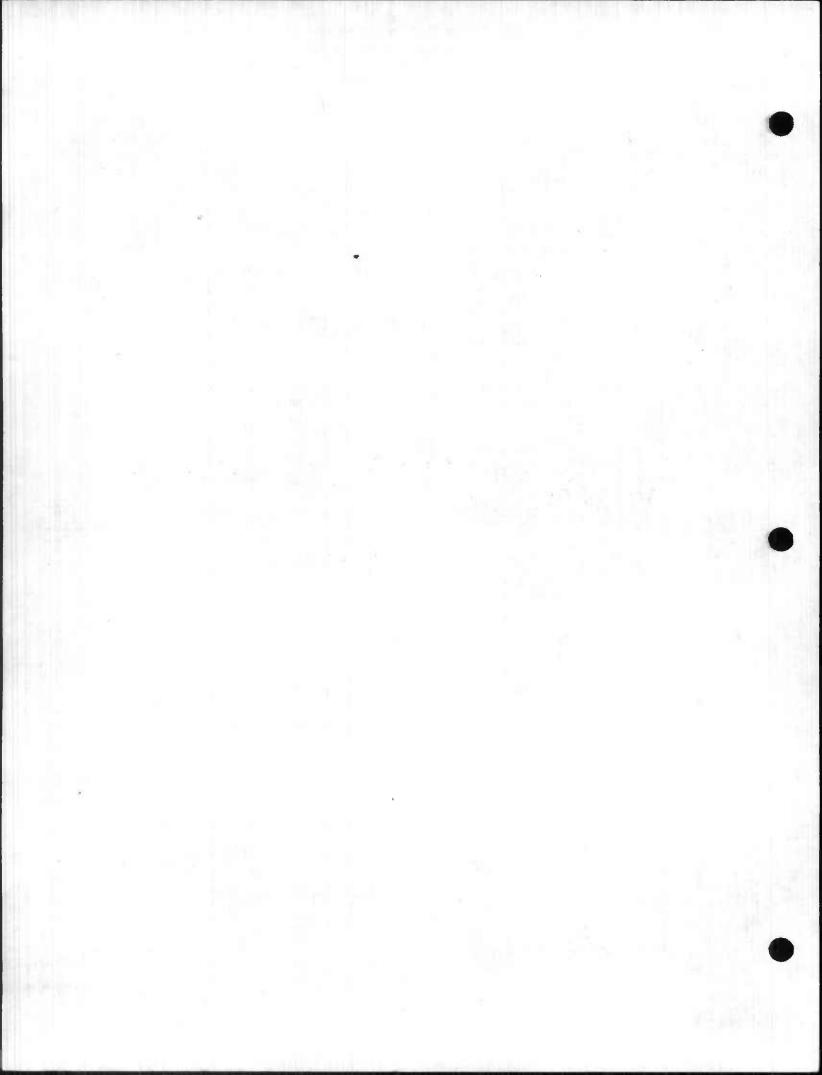
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 04626 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 28, 2000 Anna Marie Tulpinski 5:40 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Randolph Hills Nursing Home Wheaton Montgomery Birthplace (State or Foreign Country) If Under 24 Hrs 5. Social Security Number 6. Sax 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Dec. 15, 19 **Funeral** Days Hours 1 □ M 2 🖫 F Months 80 1919 202-10-7210 Dec. Pennsylvania Director Usual Rasidence of Decedent 10a. Stata 10c. City. Town or Location 10b. County 10d. Inside City Limits Gaithersburg Maryland Montgomery 1 ☐ Yes 2 ☒ No Director 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 19410 Torran Rocks Terrace 20879 United States 238 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status "risturel", or Item ledical Examiner Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Tyes 2 No. Specify: Specify: White by 3 X Widowed 4 ☐ Divorced Hypiens. other than "naturn ent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental P Important: If them 27 is marked of any Injury or other traumetic eve Stephen McGary Winifred Kerwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19410 Torran Rocks Terrace, Gaithersburg, MD 20879 Donna Stefanick/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb. 2, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removat from State 2000 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, 21. Signature of Funeral Service Licensee Rockville, Maryland 20850-2805 M00689 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or head failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Finat disease or condition resulting in death) Acute Myocardial Infarction Examiner Dua to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, laading to immadiate cause. Entar Underlying Cause (Disease or trijury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) 88 980 P.O. Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Severe Dementia Records, þ 24b. Wera sutopsy findings available prior to 24a. Was an autopsy performed? Completed Dehydration completion of cause of death? The law page 2 2 1 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case raferred to medicat examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funerel Director: 6 Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 6 4 Homicide filled in Hospital 1 🖔 Certifying Physicien: To tha best of my knowledge, death occurred at the time, data and place, and dua to tha cause(s) and manner as stated. edical 29a. Certiflar To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Data aigned (Month, Day, Year) D09834 January 29, 2000 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) Barry N. Rosenbaum, M.D. 3720 Farragut Avenue, Kensington, MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 2 2000

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 31 IRVING TILGHMAN, JR. 2000 WILLIAM Jan. 0930 /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Cambridge Dorchester Mallard Bay Care Center If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) July 14 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funerai** Months Deys Hours 215-20-0749 1925 Maryland TE M 2 □ F 74 Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Cambridge Dorchester 1∰Yes 2□No Director 28a-f1 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. Ather than "natural", or thems 23s or vert, the Medical Examiner must be. 412 East Appleby Ave. 21613 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 15 yes 2 No If Yes, Give Yeer or Dates: 1944-46 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 ☐ Never Married 254 Married Baltimore, Maryland 21215-0020 white 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementery/Secondery (0-12) College (1-4or 5+) hardware retail clerk permit. Pages 1 and 2 should be find Department of Health and Mental Hy Important: If item 27 is tranked other any injury or other traumatic event. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Elizabeth Meredith William Irving Tilghman 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 412 E. Appleby Ave., Cambridge MD 21613 Annalorraine Tilghman-wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State Maryland Veterans Cemetery 2-3-00 Hurlock, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betw **Physician** /Medical Immediate Cause (Final eumonia disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner ages or Attending Physician: The law requires that the death certificate be executed the buriel-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): be detached for use es Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of deeth? Plabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings evallable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? page 2 should 1 ☐ Yes 2 2000 certificate Be 25. Wes cese referred to medical exeminer? 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 20No this funeral 28a. Dete of tnjury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? After 1 Neturet 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

Madical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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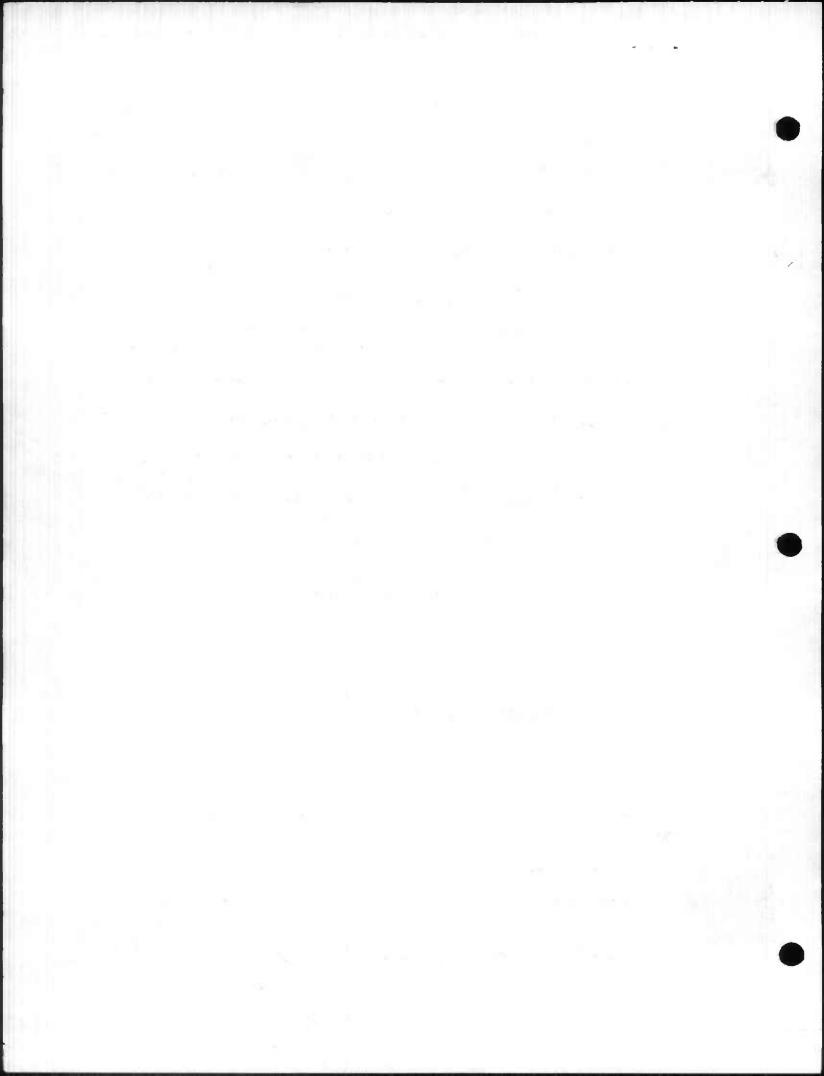
32. Registrar's Signeture

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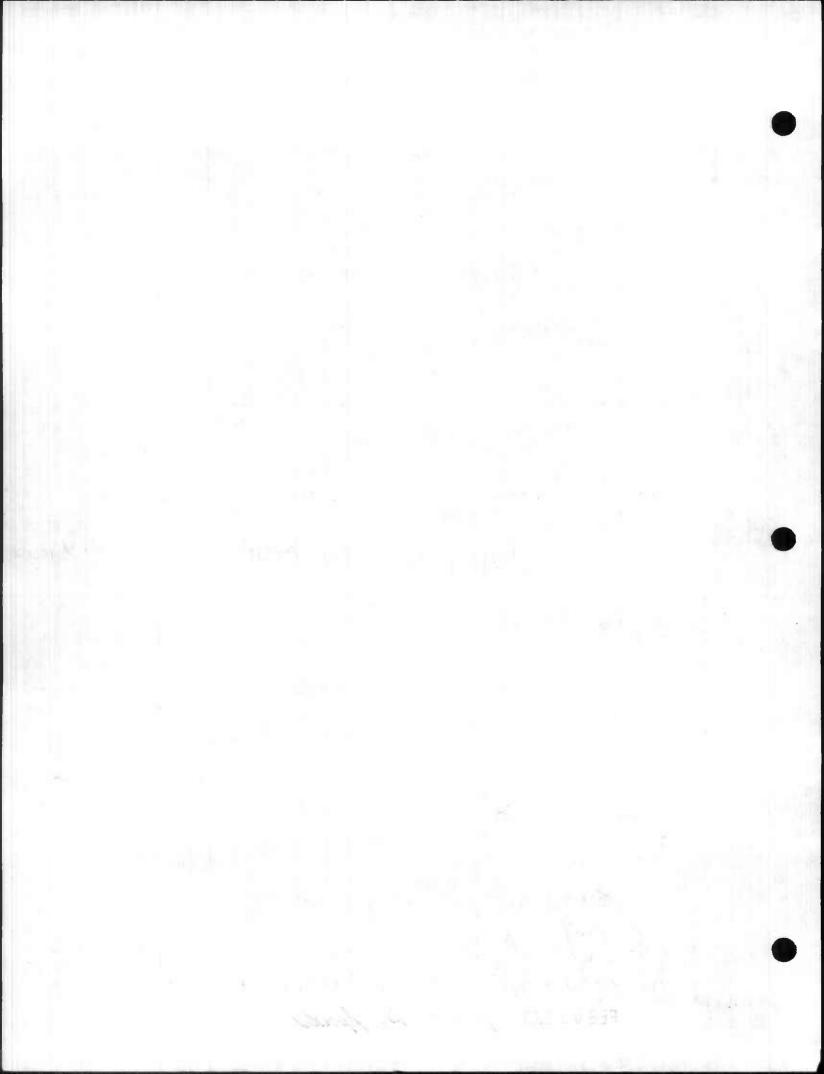
Cambridge, MD

State Registrar ZUGENE NEW.
31. Dete filed (Month, Day, Year)



Amended Item #29c, Per Carroll County, 02/01/2000, cew Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** JANUARY 27 2000 04:24PM LEE TURNER AMBER /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Sept. 16, 1999 Birthplaca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days 219-55-8513 Yrs. Director Maryland 4 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or itema 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified as 1 Yes 2 No Carroll New Windsor Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1594 Smiley Drive 21776 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health end Mental Pygiene. Important: if item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No White Specify. Specify: ð 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 0 None None 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Jeffrey J. Turner Angela M. Schisler 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey J. Turner/Father 1594 Smiley Drive New Windsor MD 21776 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Park 2/2/2000 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jeffrey N. Zunbrun Funeral Home 21. Signature of Funeral Service Licenses 6028 Sykesville Road Eldersburg, MD 21784 23a. In the the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, mock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) 1/2 months /Medical **Examiner** Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burist-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) Pert It. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? signed by 1 Yes 2 0 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? completion of cause of death? 1 □ Yes 2 00 1 Yes 2 No 25. Was case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Monatient Medical Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1. Meturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29e. Certifier and menner steted. 29b. Signeture end title of certi 29c. 1 13638 29d. Date signed (Month, Day, Year) 600 N. Wolfe ST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The M.D. Johns tapkins Children's Centor Lexand 31. Dete filed (Month, Dey, Year) State FEB 0 1 2000 Registrar

DHMH 16 Ray 6/95



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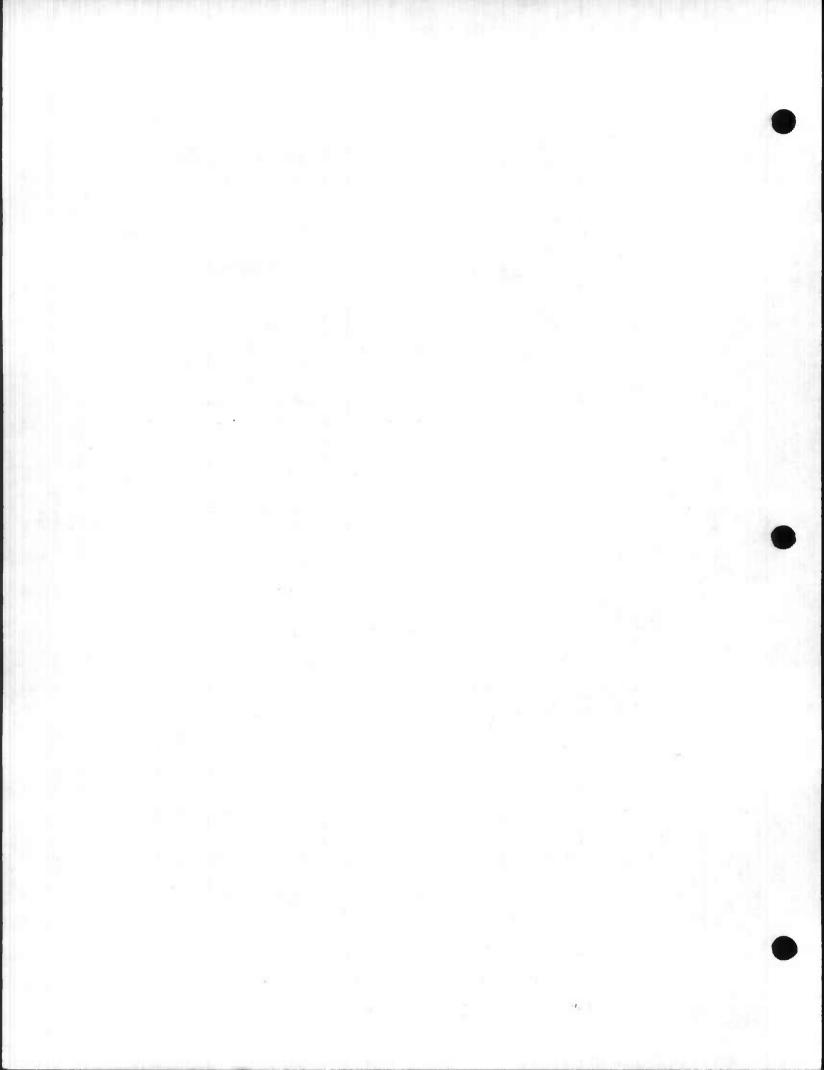
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State of Maryland / Department of Health and Mental Hygiene 0 0 4630

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DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 30 **Physician** Madale L. Teagle 01 00 /Medical 4a. Fecility Name (If not Institution, gike street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Risfield
If Under 24 Hrs. 8. Di NURSING BURD awes HOME OMERSET 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign County) **Funeral** Months Days Year) Hours Min 1□M 2XF 214-32-5835 94 Yrs. Director South Carolina 07-07-05 Usual Residence of Decedent with the Maryland Show 10a State 10c. City, Town or Location 10d, Inside City Limits th end Mental Hygiene. 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Ris field 1 Yes 2 No Completed by Funeral Director - OMERSET 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 326 Somes 21817 U.S COUE death 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours efter on not of Heelth and Mental Hygiene. At: If item 27 is marked other than "natural", or item Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: BACK 3 ₩ Widowed 4 Divorced 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Sea food College (1-4or 5+) LABORER 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Nocris P ARENCE NORRIS mnie 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) or other tran P.O. BOX 118 STATION AWSON - Daughter MARIOR EV: 4hA MD 21838 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stete Depertment of Important: If any injury or EBENEZER U.M.C. Comedy MARUMSCO, MD 2-5-00 4 ☐ Donation 5 ☐ Other (Specify) Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Licenses Funeral Homo Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final Atherosylvatic cardioressular discare 413. disease or condition resulting in deeth) Examiner Physician/Medical Examiner Dementra The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? yd bengis 1 Yes 2 No 3 Probably 4 Unknown þ 8 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? After this certificate hes been 20 No 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) To the Hospital or Attending rings... within 24 hours after death. To the Funeral Director: After this c Other: Nursing Home 5 Residence 6 Other (Specify) L₀ 1 Yes 22 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth Certification: 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Medicai Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the ceuse(s) end manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifler (Check only one) 29b. Signeture end title pf cartifier 29c. License number 29d. Date signed (Month, Day, Year) wherely DR-U-Natuan 0051359 301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. USHA NATESAN. M.D CRISFIELD, MD 21817. 201 HALL HIGHNAY 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

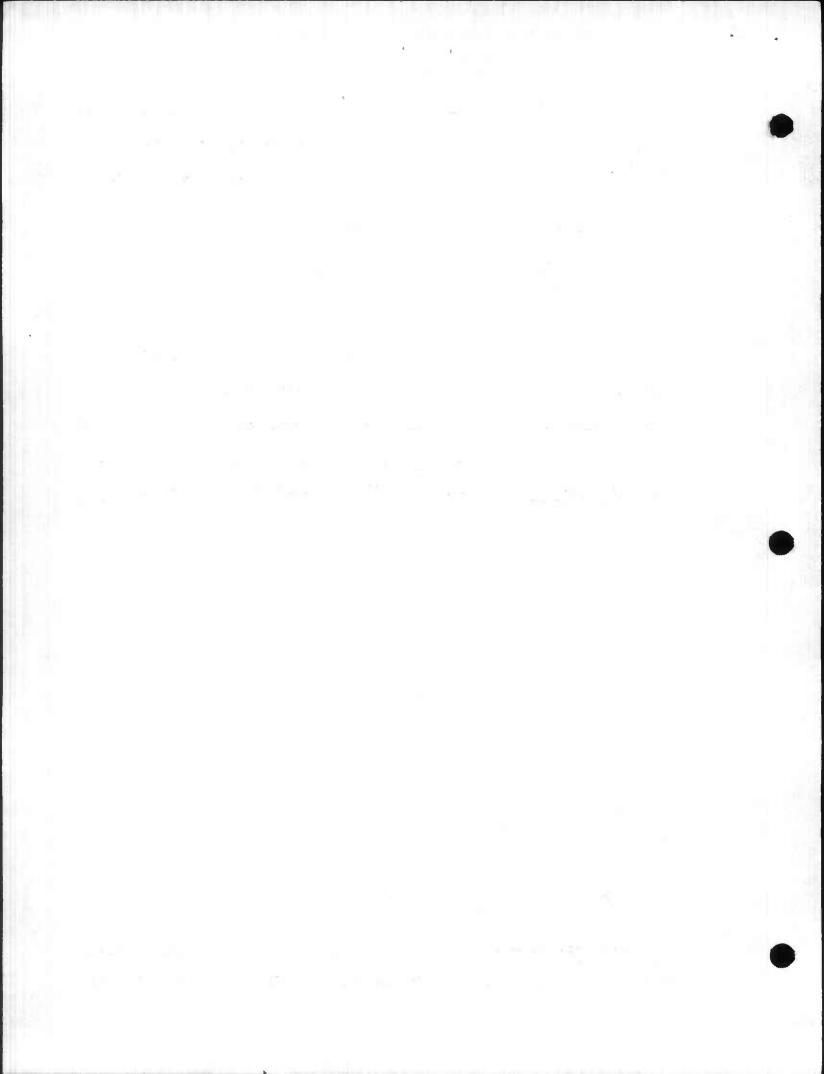
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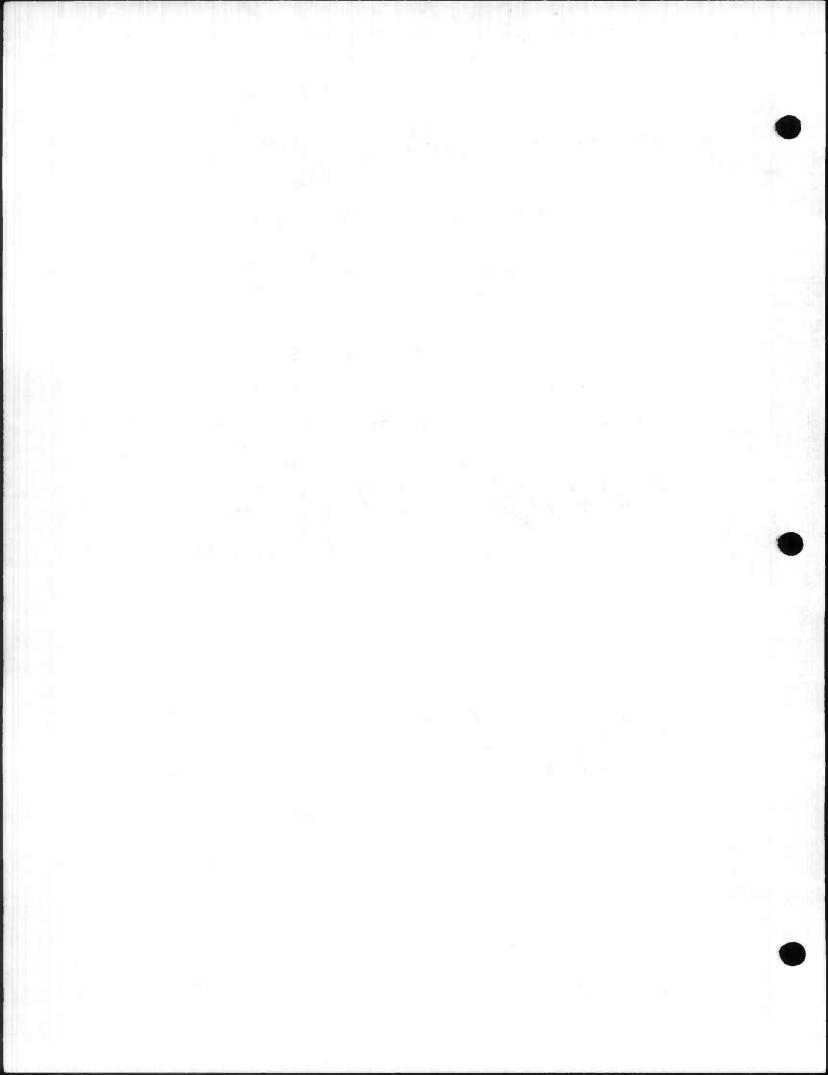
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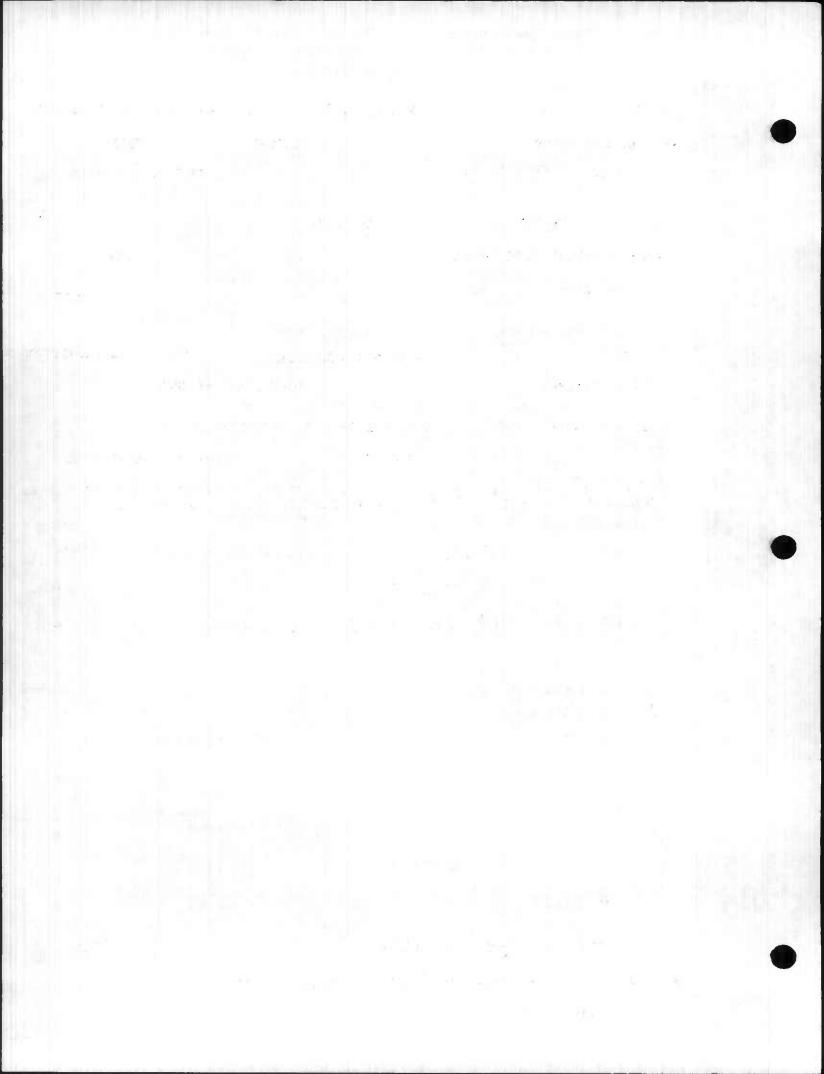
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State of Maryland / Department of Health and Mental Hygiene 0 0 4634

					Certificate	of i	Death		R	eg. No.							
		1. Decedent's Name (First, Middla, L	ast)						2. Date of Dea		Maria	3. Tima of Death					
	Physician	RAYMOND FRAN	CIS	TATA	eisman	. SF	۲.		Month January	Day 7 25,	Yaar 2000	1:40am					
	/Medical Examiner	4a Facility Neme (If not institution, gr			ELSINAII.			- July	cation of Death		ty of Death	1. Toam					
	Examiner	WILLIAM HILL MAN					EAC	TON			TALBO'	T.					
-	Funeral			(In yrs. last birth	tay) If Under	1 Year	If Under	24 Hrs.	8. Data of Birth (Month, Day			laca (Stata or Foreign try)					
н	Funeral Director		11XM 2□F 78	, ,	Months	Days	Hours	Min.	OCT. 28	, Year) 1921	MARY						
Н		Usuet Residence of Decedant							001. 20	,1721	IMINI	DAND					
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	r kems 234 other must	11. Marital Status	12. Was Decedant Ev		13. Was Decede			ain? (Spe	ecify Yes or No-	14. Bo	ece - Amaric	an Indian,					
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<u>∞</u>	DSNA																
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4	. /Medical	Immediata Causa (Final diseesa or condition	asy	wate	m 1	N	lun	m	~			3 days					
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	or view or	LSG. Organizate date discontinual	10 Alali	1	MD	1.		711		11.	5//	06					
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		WILLIAM H. WOOD,			LEWILD A	VEN	UE, E	ASTO	N, MD 2	1001							
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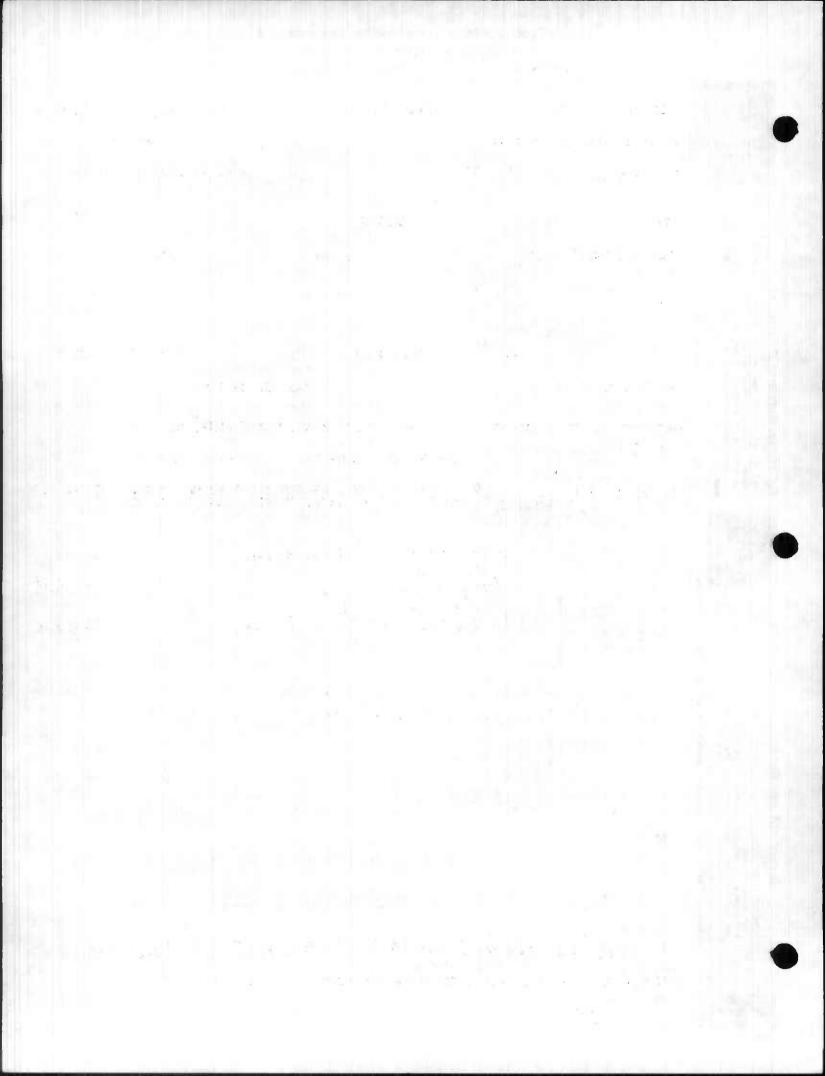


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Physician	_	. Decedent's Name	e (First, Middi	la, Last)						2. Data of Dee Month	Day Day	Year 3. T	ime of Death		
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Examine	r	a Facility Nama (II	f not institution	n, giva stre	et and nun	nber)			4b. City, Town, or	Location of Death	4c. County	of Death			
	-	WILLIAM I						Williams & Voc	EASTO			BOT			
Funeral Director		. Social Security N 213-05-62		6. Sex 1 ☐ M	⊉ CXF	7. Age (In yrs 92	. last birthday) Yrs.	Months Days		8. Data of Birth (Month, Day APR. 9,	1907	9. Birthplece (5 Country) MARYL	Stete or Foreigi AND		
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how how		Oa. Stata	10b. County			10c. C	ity, Town or Lo	cation				t0d. Inside City Limits			
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4 2 th	ole o	0e. Street and Nur						10f. Zip Coda			10g. Citizen of \	What Country?			
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ond I bue		19a. informant's Na	me/Ralations	ship <i>(Type</i> ,	Print)		19b. Mailin	g Addrass (Stree	et and Number or A	ural Routa Numbe	er, City or Town,	Stata, Zip Code))		
Health tem 27		OMER DUL	IN, JR	. / N	EPHEW		13624	DULIN	ROAD, QUE						
5 5 5	2	1X Buriel 2		3 ∏Bam	ovai from !		Place of Dispo camatary, cran	sition (Nama of setory or other pl	lace)	Data	20c. Location	City or Town, St	lata		
	4 □ Donation 5 □ Othar (Specify) SPRING HILL CEMETERY 1-29-00 EASTON, MD														
Department Important: I any Injury o		21. Signatura of Funarai Sarvice Licensee 22. Name and Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A													
40 5 % Q		7141.	~ NLE	well	am'	UCT	20	0 S. HA	RRISON ST	., EASTO	N, MD 2	1601	L, I.A.		
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LE F	3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28b. Location (Streat and Numb City or Town, State)									ber or Rurel Rout	te Number,				
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within 24 hours at To the Funeral DI completely filled in		9b. Signatura and	titla of certifia	ır	dire mani	ימי סומוטט.	<u> </u>	29c. Licar	nsa number		29d. Date signe	ed (Mooth, Day, Y	Year)		
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Registrar

State 31. Data filed (Month, Day, Year) 32. Registrar's Signatura JAN 2 7 2000



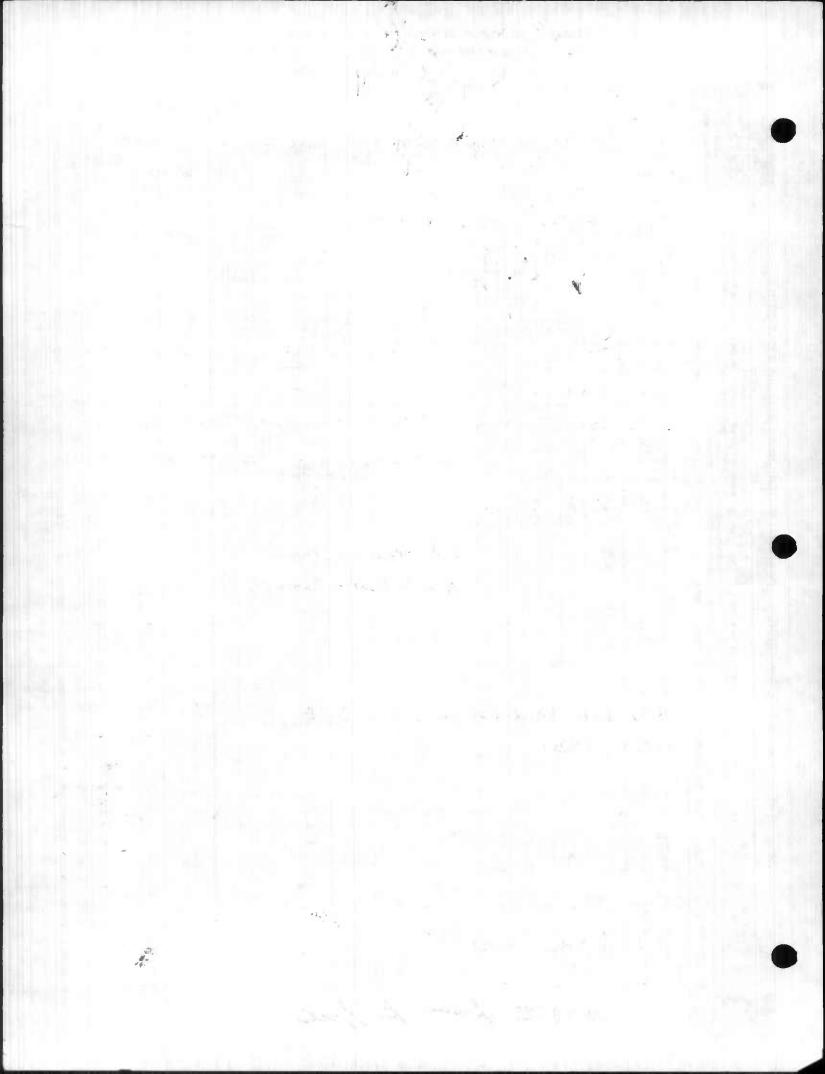
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #8 PER F.H. G783State of Maryland / Department of Health and Mental Hygiene 00 04636 AMEND ITEM: #1 PER PHY G781 3-31-2000 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** WILMER LEVERSON WILMORE LEVERSON. 01 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** OF MR DOUGLAS 418 HIGH ST KENT JONES HESTERTOUN 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth 1920 (Month, Day, Year) O4 25 5. Social Security Number 6. Sex 9. Birthplace (State or Foraign **Funeral** 1 1 M 2 □ F 215-14-3299 Director Usual Rasidence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours effer deeth with ment of Health and Mental Hygiena.

Intel Hern 27 is marked other than "natural", or itema 23a or any or other traumatic event, the Medical Examples must be a USA 21620 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedant Evar in U,S.
Armed Forces?

1 12 Yes, 2 12 No
If Yes, Give
Year or Dates: W U II 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK by 3 2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Coilege (1-4or 5+) TRUCK DRIVER CLOVERLAND DAIRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 88 Emma (DIEMAN WILMER WHO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DONER DE 3916 PEACHTREE RUN. DELORES SETH . DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata permit. Page Department o Important: If any Injury or 02.01.00 WORTON 4 □ Donation 5 □ Other (Specify) CCOL CEMETERY 22, Name and Address of Facility 21. Signature of Funeral Service Licensee 23a Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CHESTERTOWN Approximete Interval Between Onset and Deeth **Physician** Cou dio Respiratory Arrest /Medical Immediate Cause (Final Elious disease or condition resulting in death) Examiner Artero Sclevotia Cardio Vascular Disease Examiner physician end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) for use Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? HTN, TIA, Cardid Stemosis, Prostate CA 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? HackA., Allo1. completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical examiner?

1 Yes You've You've Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Naturel death. 2 No invastigetion 2 Accident after death n 24 hours after des Ne Funeral Director pletely filled in by th 6 Could not be delermined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

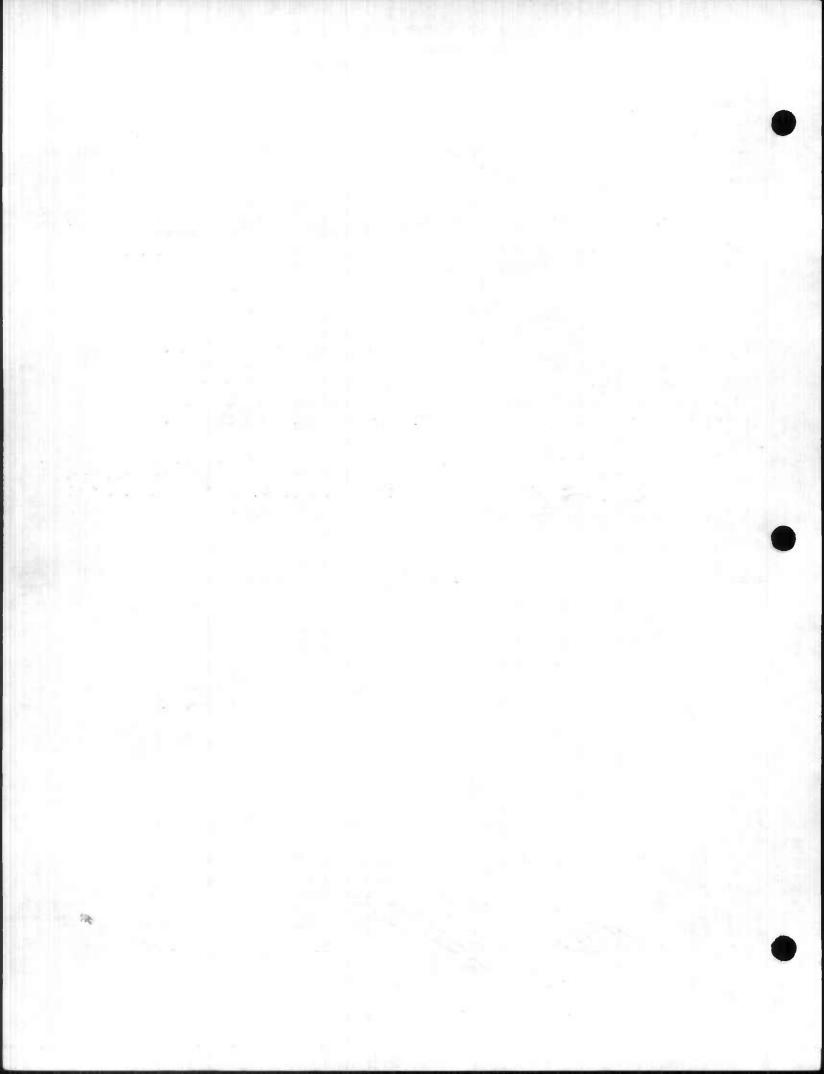
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Qala signad (Month, Day, Year) 29b. Signature and title of certifier 800 Delle 50996 00, 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) NEIL STODDARD M.D. 100 BROWN ST TI10 21620 CHESTERTOWN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2000 Registrar



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State of Maryland / Department of Health and Mental Hygiene 0 0 4 5 3 7

				Certific	cate of	Death			Reg. No.					
	1. Decedent's Nama (First, Middle, L.	ast)						2. Date of Dec	nth	V	3. Tima of Death			
Physician	Bronia		Wa	lsh				Jan. 3	Day 1, 2000	Year	6:40 AM			
/Medical Examiner	4a Facility Neme (If not institution, gi	ive street and number)	· · · · · · · · · · · · · · · · · · ·	1911		4b. City, To	own, or Lo	ocation of Death	1	y of Death	0.40 111			
Examine	Potomac Valley N	Jursing Home	2			Rockv	ille		Mont	gomer	v			
Funeral			(In yrs. last birt	ruay/	nder 1 Yaer	If Under	24 Hrs.	8. Date of Birt			place (State or Foreign			
Director	016-07-2295 Usual Residence of Decedent	1□ M 2\ F 86	```	frs. Mor	iths Days	Hours	Min.	Nov. 1	y, Year) 5, 1913	Gre	enfield, Ma			
9 B 11	10a. State 10b. County		10c. City, Town	or Location)					1	0d. Inside City Limits			
with the Mary t or 28e-f sh be notified.	Md. Montgome	ery	Rockvi								1 □ Yes 2 □ No			
	610 Farm Pond La	ane		10	7. Zip Code 20852				10g. Citizen of U.S.		try /			
3 28 5	11. Meritel Stetus 1 ☐ Nevar Merried 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Dates;				lispanic Or an, Mexica Specify		ecify Yes or No- Rican, etc.)	Specif		etc.			
2 hos ted	15. Decedent's E	ducation	16a.	Decedent's	Usuel Occup	pation		,	16b. Kind of B	Whi Business/Inc				
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Cor the		4+		Attori	ney					.S. Government				
Maryland 21215-0020 of 2 should be filled within 72 hours at the and Mental Hygisene. 77 is marked other than "natural", or trearmetic event, the Medical Exam? To Be Completed by F	17. Father's Neme (First, Middle, Las Joseph Ripka	t)				1000		e (First, Middle, Oczetar:		umame)				
lary 2 shot and la	19a. Informent's Neme/Relationship	(Type, Print)	19b.	Meiling Add	iress (Street	and Numb	er or Rur	al Route Numbe	er, City or Town	, State, Zip	Code)			
Manual Summary and a ser trans	Tobey Kaczensky	/ son	61	0 Fari	n Pond	La.,	Roc	kville,	Md. 20	852				
offis and offis	20e. Method of Disposition		20b. Plece of	Disposition	(Neme of			Dete	20c. Location		wn, Stete			
Saltimore, emit. Papes 1 an epartment of Heal montant: it Item 2 ny Injury or other finds.	1 Buriai 2 Cremetion 3 € 4 Donetion 5 Other (Special Content of the Content		St. Staneslaus Cemetery 2/5/2000 S. Deerfield, Ma											
in the state of	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc.													
00 40148	5130 Wisc. Ave. NW., Washington, D.C. 20016													
Physician /Medical Examiner	23a. Part1. Enter the disease or conshock, or heart feilure. List only immediate Cause (Finel disease or condition resulting in death)	a. Uremia	a. Dua to (or as a c	onsequence	e of):					1 3 0 4 3	Approximate Interval Between Onset and Death			
min uted	Arteriosclerotic Renal Vascular Disease Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying													
6876 flicate be g physicia as the bu	Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of):													
Box set certification of the set														
D. B s des s des the at the at sed fc	Pert II. Other eignificant conditions	contributing to death but	not resulting In	the underly	ing cause giv	en in Pert	I.	23b. Did 1	lobacco use co	ontribute to	the cause of death?			
IS, P.O. BOX es that the death ce igned by the attendi be detached for use by Physician/								10	Yea 2 No	3 Pro	bebly 4 Unknown			
aw requires been s 2 should									an autopsy med?	av co	ere autopsy findings allable prior to mpletion of cause death?			
The tare he page								101	res 20 No	10	Yes 2□ No			
Vital Indican: The contilicate rector, page Co	25. Was case referred to medical					26. Plac	e of Deat	h (Check only o	ne)	1				
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DIVISION To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of e	my knowledge, examination and	deeth occu	rred at the tir ation, in my o	me, date ar opinion, des	nd place, ath occur	and due to the red at the time,	cause(s) and m date end place	anner as s , and due to	tated. the cause(s)			
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10	*WXLL	18/	10/1	1	D01	.120		F	eb. 3,	2000				
	30. Name end address of person who				. 1	Const	· 24	14 2000	2_2/11					
State	Walter Goozh, MD	. 1299 Lamb	's Signature				ıg, M	10. 2090	2-3411					
Registrar	31. Date filed (Month Cay, Year) FEB 04 2	000 pener	va /	9. 1	park	2								



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** January 31, 2000 9:40 pm Margaret Boyce /Medical Walters 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring
| Munder 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9202 Worth Avenue Montgomery
9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🔯 F Yrs. Director 218-56-7555 Jan. 15, 1902 New York Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or home 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Silver Spring Maryland Montgomery 2 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9202 Worth Avenue 20901 USA 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Black, White, atc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Health Care Registered Nurse permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked orbh any Injury or other traumatic event and Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph Boyce Ann Cecelia Bartlett 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 9202 Worth Avenue Silver Spring, Maryland 2 Alice W. Gilson (daughter) 20e. Method of Disposition 20b. Plece of Disposition (Nama of cametery, cremetory or other plece) Date cometery, cremetory or other piece)

Long Island National Cemetery 1 Burial 2 ☐ Cremetion 3 ☑Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Pine Lawn, New York 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock/or/haert feilura. List only one cause on each line. Approximate Interval Between Onset and Daeth **Physician** /Medical Immedieta Causa (Finel disaase or condition resulting in death) Examiner Due to (or as a consequence of): Examiner that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): USB for 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other alonificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2500 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 has 2 DeNo 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Placa of Death (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5 Residence 6 □Other (Specify) Certification: To this 28a. Dete of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 27. Menyfer of Death 28c. Injury at Work? 28b. Time of After or Attending 1 Netural 2 Accident 5 Pending To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yas 2 ☐ No investigation 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide edicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and mannar steted. onel 29d. Date signed (Month, Day, Year) 29b. Signeture 29c. License number and title of certifier SUVE 10 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 11251 Lockwood Dr., Silver Spring, MD 20901 Pamela_M. Mulshine

Registrar

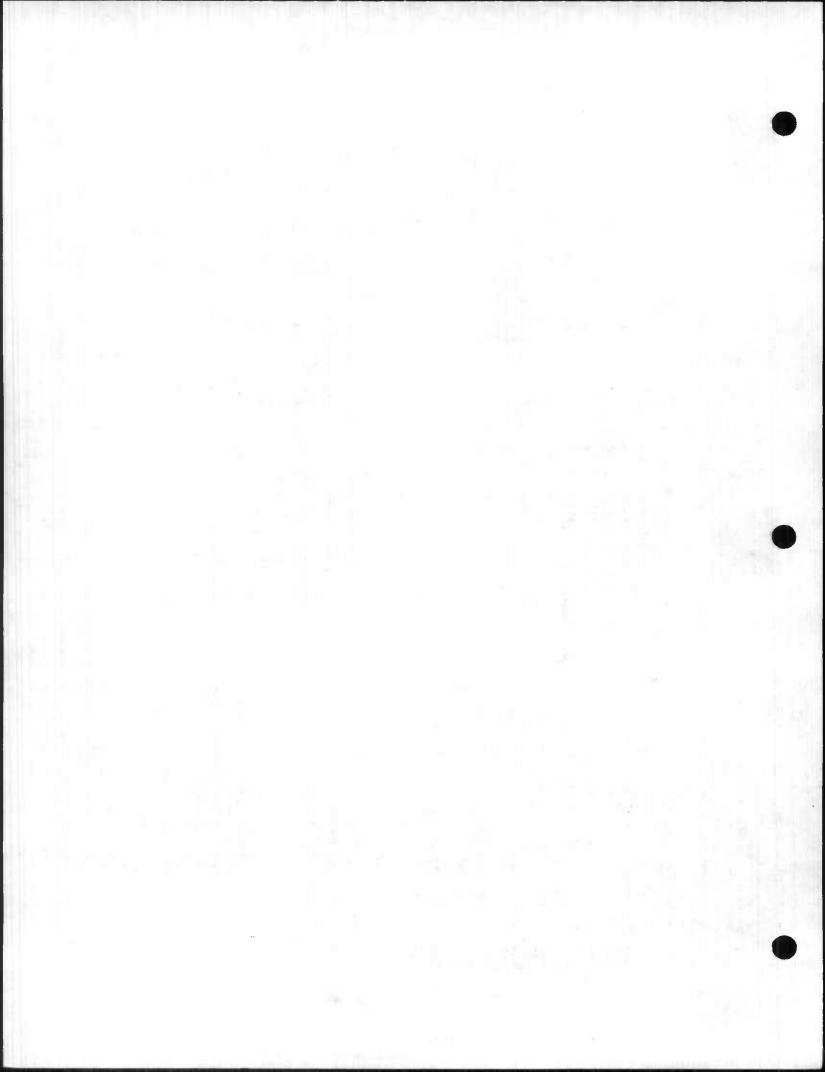
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32. Registrer's Signeture



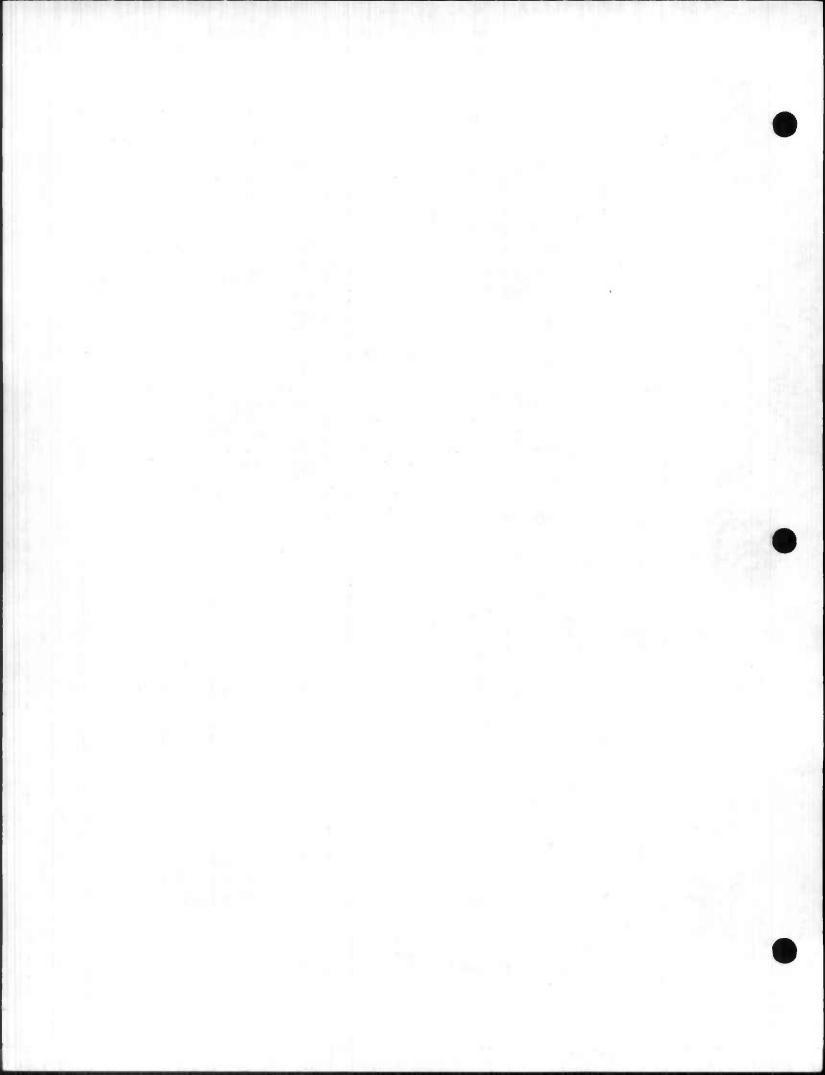
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Year **Physician** Frederick William Whitt 30. 2000 1:30 PM January /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** 713 S. Surf Road Worcester Ocean City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 M 2□F 92 Yrs Director 577 10 4080 Aug. 31, 1907 Nebraska Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. fnslde City Limits 1 XYas 2 No Maryland Worcester Ocean City Director 28a-f 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? must be r 713 S. Surf Road U.S.A. 21842 Funeral Berns ... 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: White à 3 ₩Widowed 4 Divorced Year or Dates: WWII Completed .

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Truck Driver Laundry Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H tant: If them 27 is marked off lury or other traumatic even 88 William Whitt Theresa Christman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Whitt (son) 12-H Ridge Road, Greenbelt, Marylnad 20770 20b. Place of Disposition (Name of 20a. Mathod of Disposition Date 20c. Location - City or Town, State Uniformed Services 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/31/2000 University of the Health Sciences Bethesda, Maryland 4 ☑ Donalion 5 ☐ Other (Specify) 22 Name and Address of Facility Rapp, Funeral & Cremation Services, Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, MD 21. Signature of Funeral Servi M00956 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician /Medical Immediata Cause (Final disaasa or condition resulting in death) Examiner Due to (or as a Examine ician and burial-transit lown The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Cer Physician/Medical Due to (or as a consequence of) 98 signed by the at the detached for Part ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Wera autopsy lindings available prior to 24a. Was an autopsy Completed completion of cause of death? page 2 1 □ Yas 2 No 1 ☐ Yes 2 No Division of Vital Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 □ Nursing Home 5 ☒ Residence 6 □ Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Attending 5 Pending investigation 1 WNatural death. 1 TYes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) within 2 # 29b. Signature and title of certiful 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert F. Baumann, M.D., 560 Riverside Dr., #B-204, Salisbury, MD 21801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 2000 Registrar

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Physician /Medical **Examiner** that the death certificete be executed buriel-tran and P.O. Box 68760. physician the

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Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be 2 Certification:

Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 ☐ Yes → No 25. Was case referred to madical 26. Plece of Death (Check only one) exeminer? 1 Yes 2 To Other: 4 ☐ Nursing Home XXX Residence 6 ☐ Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Magner of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Tima of Injury 5 Pending 1 ☐ Yas 2 ☐ No 2 Accident Investigation 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

Medical

29a. Cartifiar (Check only one)

29b. Signature end title of certifier

29c. License number D28352

1 X Kertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated.

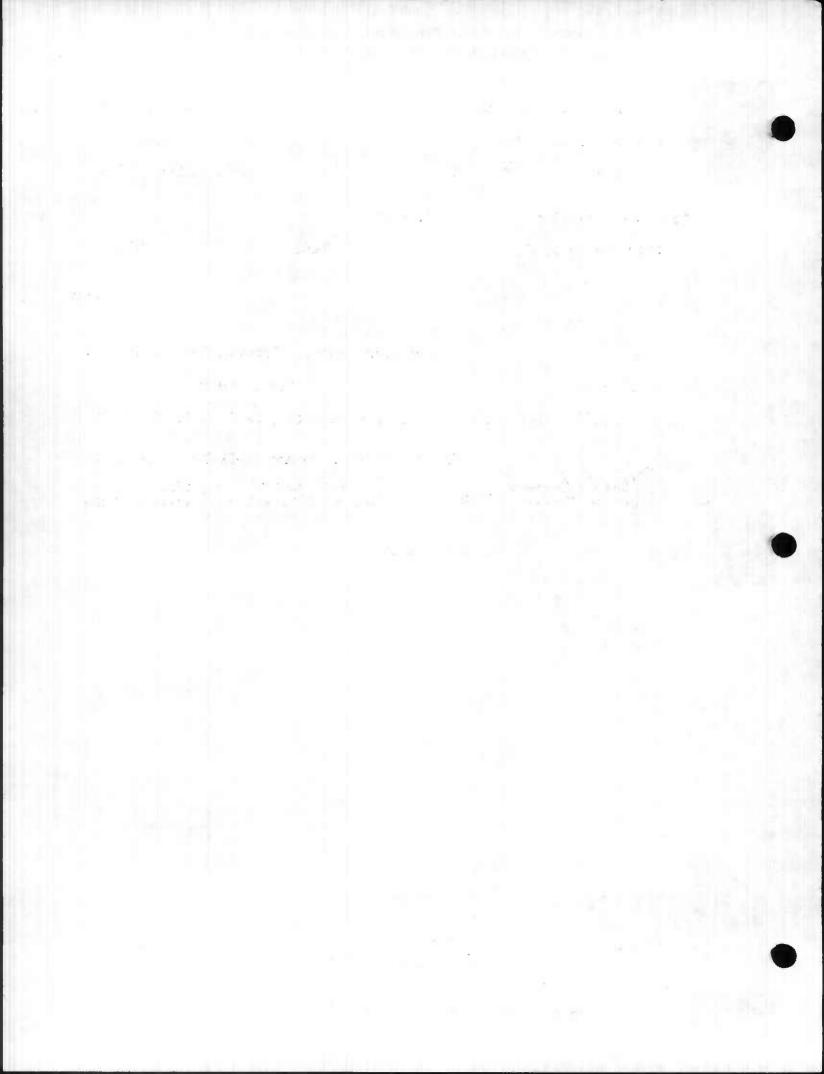
29d. Date signed (Month, Day, Year) February 1, 2000

30. Name end eddress of person who complated causa of daath (Itam 23a) (Type, Print)

MD., P.O. Box 1703, la Plata, MD 20646 Krishan Mathur,

31. Data filad (Month, Day, Yaar) 32. Registrar Signature FEB 0 4 2000 ▶

bouls



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04661 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day AGNES ANN WINDSOR JANUARY 31, 2000 12:35 AM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 9767 Radford Street Waldorf Charles if Under 24 Hrs. 8. Date of Birth Hours Min. 8. Date of Birth (Month, Dey, Year) March 27,1920 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months Deys 1 M 2 X F Yes 578-70-8852 79 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Waldorf Maryland Charles 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9767 Radford Street 20603 U.S.A. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Reca - American Indien, Black, Whita, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Harrison Wade Windsor Eliza Ann Boswell 19e. Informent's Name/Reietlonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9767 Radford Street, Waldorf, Maryland 20603 Janice Pollak/Daughter 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 02-04-2000 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 21. Signetural Funeral Service Licensee 22. Name and Address of Eacility The Huntt Funeral Home, Inc MARK S. BRANSON M00871 P.O. Box 156, Waldorf, Maryland 20604 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finai stio nu disease or condition resulting in death) roman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Deve en 800 at a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 26. Piace of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 55 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

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Department of Health and Mental Hygiene.
Eimportant: If flem 27 is marked other than "na Sany injury or other treumatic event, the Media page.

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Baltimore,

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Division of Vital Records.

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25. Wes case referred to medical examiner? 1 Tyes 20 No 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. tnjury et Work? 1 DiNaturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated. (Check only

Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signature and title of

29d. Date signed (Month, Day, Year)

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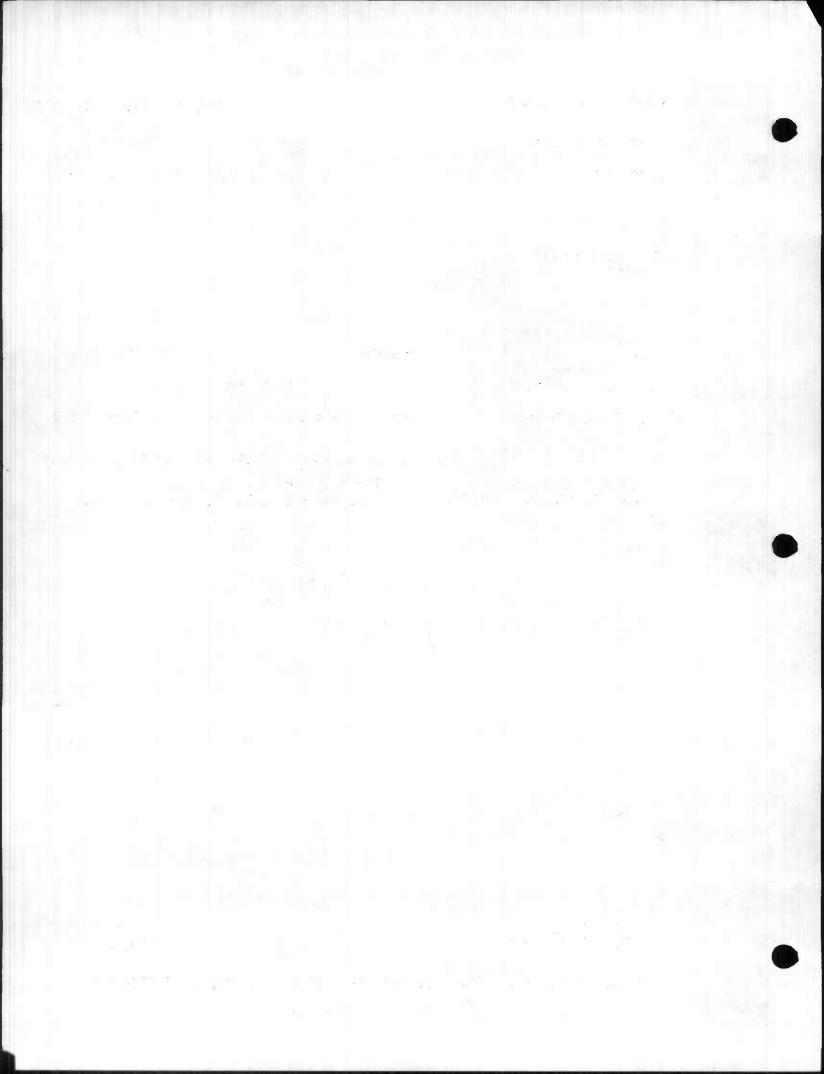
30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

DANIEL M. HOWELL, MD., 11345 PEMBROOKE SQ., #104, WALDORF, MD 20603-4804

State Registrar

edical

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 4 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04642 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Year 01in Calvin Woolford 23, 2000 January 8:55 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Mallard Bay Care Center Cambridge Dorchester | Months | Days | Hours | Min. | April 17,1913 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F 213-12-5968 Yrs. Director 86 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Dorchester Cambridge XXYes 2 No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 517 Academy Street 21613 US Was Decedent Ever in U.S. Armed Forces?
**TAYes 2 No
If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married XX Married 1 ☐ Yes 2 No Specify: White þ WW II 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Hardware Store . Fages 1 and 2 should be tiled w ment of Health and Mental Hygler fant: If Item 27 is marked other th fury or other traumatic event, tha 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Anna Lucille Greaves Henry Clay Woolford 19a. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 517 Academy Street Cambridge, Maryland 21613 Gladys T. Woolford Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State XX Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 1/27/2000 Hurlock, Maryland 22. Name and Address of Facility
Thomas Funeral Home, P.A. 21. Signeture of Funeral Service Licensee 700 Locust Street Cambridge, Maryland 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ page 2 should be Be Completed 24b. Were eutopsy findings available prior to 24e. Wes an autopsy completion of cause of death? certificate has 2000 1 ☐ Yes 28 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Surviving Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dev Year) 28b Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1-Expatural 5 Pending 1 Tyes 2 No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 29a. Certifier

P.O. Box 68760. Division of Vital Records.

The law requires that the death certificate be executed To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely

filed within 72 hours after

Baltimore, Maryland 21215-0020

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) end menner es stated.
2 Madicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1/27/00. D15541. melife.

31. Date filed (Month, Day, Yeer)

VINDORAL MEHTA, MD

32. Registrar's Signature

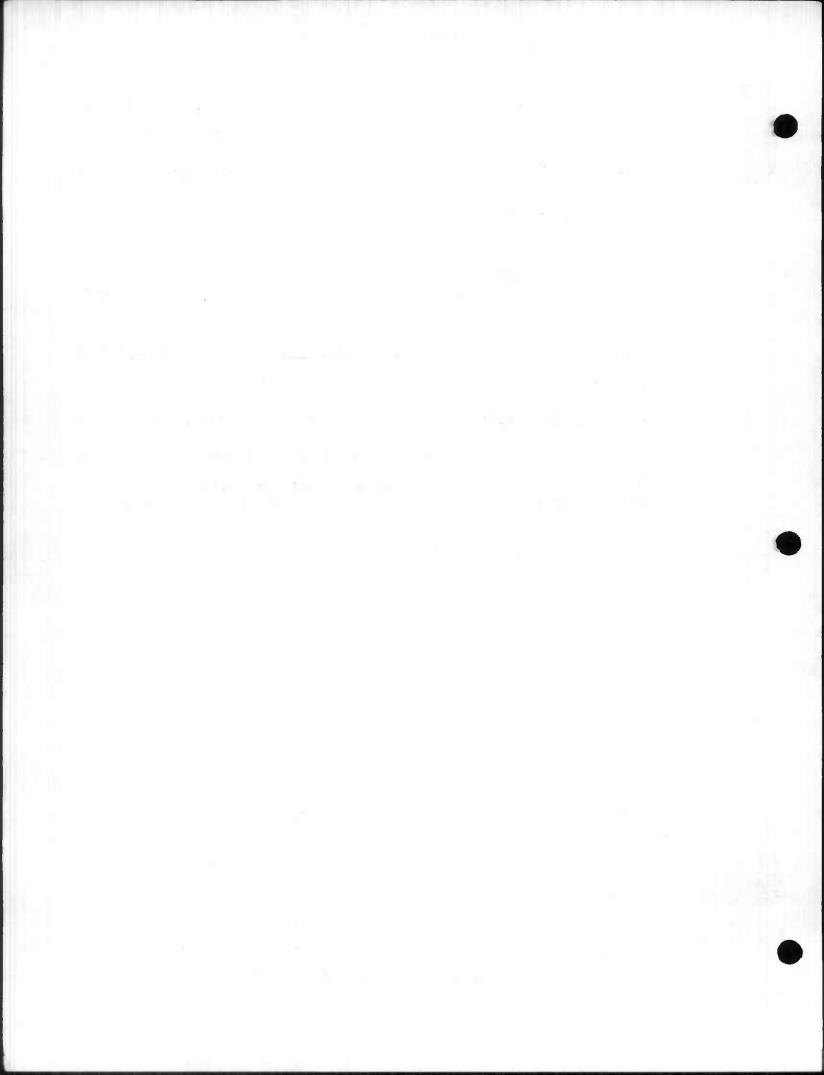
402 BYRN ST

JAN 2 8 2000

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 04643 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Mary Quinn Woodland 30 Jan 2000 11:25 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis ElderCare -The Pines Easton Talbot If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 💢 F Days 71 212-78-9920 April 8, 1928 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5013 Plantation Rd. 21613 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shellfish 10 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Homer Cannon Emily Pritchett 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois K. Woodland/Spouse 5013 Plantation Rd., Cambridge, MD 21613 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery2-2-2000 Hurlock, MD 22 Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 21. Sighatione of Funeral Service License 308 High St., Cambridge
The ty Enter the disease, or confidications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or hearffailure. List only one cause on each line. 308 High St., Cambridge, MD 21613 Approximate Interval Between Onset and Death Renal faiture

Due to (or as a consequence of);

Diabetes mellitus, insulin dependent Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Theroscherosis Sovere peripheral vasuelar disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy parformed? 25 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Hospital: Other: 4 lursing Home 5 Residenca 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending

Examiner physician and the burial-transit Box 68760, Physician/Medical ettending p Records, P.O. signed b Completed by Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director; p Be Certification: To

Physician

/Medicai

Examiner

Director

Funeral

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Completed

Be

2

Funeral

Director

than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

utment of Health and Mental Hygis stant: If Item 27 is marked other I

Physician

/Medicai

1 and 2 should be Health and Mental

Pages 1

Mary Woodland Baltimore, Maryland 21215-0020

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manger of Death

2 Accident

3 Sulcide

4 Homicide

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Investigation

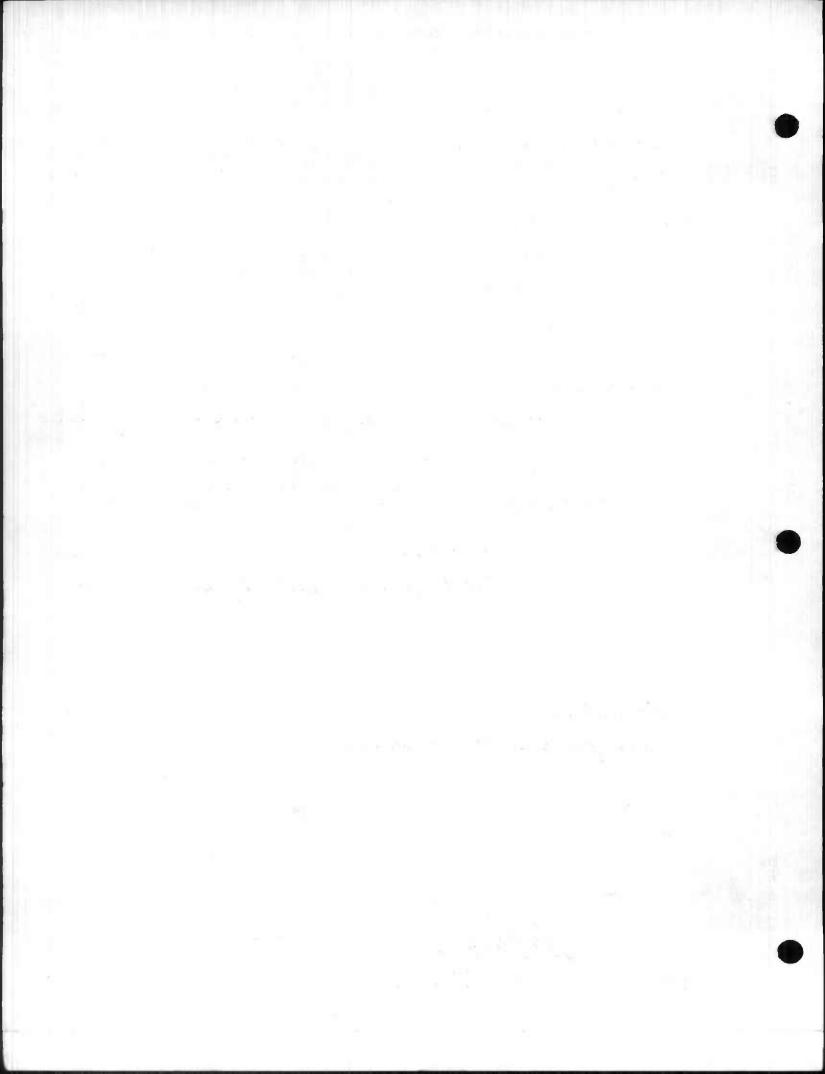
6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL CROWLEY IDLEWILD MD 508 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical



Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4 wille 18 3000 10:05 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE BON SECOURS HOSPITAL W Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. MAY 23, 1916 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1□ M 21 F 215-12-2987 Yrs. 83 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. 1 Yes 2 No BALTIMORE 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1235 N. AGUSTA AYE 21229 U.S.A. 14. Rece - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DEPT. STORE 12 TH CLERK 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surneme) RICHARD LEWIS MAE TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELVIN N. WILLIAMS 1235 N. AGUSTA AVE BALTIMORE MD 21229 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete MD Cernetery cremetory or other place). MAT MEM PK 1 Deurial 2 Ocremetion 3 Removal from State JAN 22,2000 LAUREL MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligaru 22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH enter the mode of dying, such as cardi ST FREDERICK MD 21701 23a. Part1. Enter the shock, or heart a on, or complications that caused the death. Do not enter Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably Wunknown CAncer

Physician /Medical Examine

Physician

/Medical

Examiner

Funeral

Director

must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or flems 23s or is ent injury or other treumstic event, the Medical

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Director

Funeral

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Completed

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the Meryland

Examiner To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.
To the Fuerrel Director: After this certificate has been signed by the extending physician and completely filled in by the increat director, page 2 should be deteched for use as the businely raisely. ettending physician and for use as the buriel-transit Physician/Medical by Be Completed Medical Certification: To

				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?							
				1 Yes 2 No	1 Yes 2 No							
25. Was case referred to medical	26. Place of Death (Check only one)											
examiner? 1 Yes 2 No	Hospital: 1 (Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Ott	ner (Specify)							
7. Manner of Death 1 X Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred							
29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurrent ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause(s) and murred at the time, date and place,	anner as stated. and due to the cause(s)							
20h Sinnature and title of partifier			Oc License number	20d Data sinns	of (Month Day Veer)							

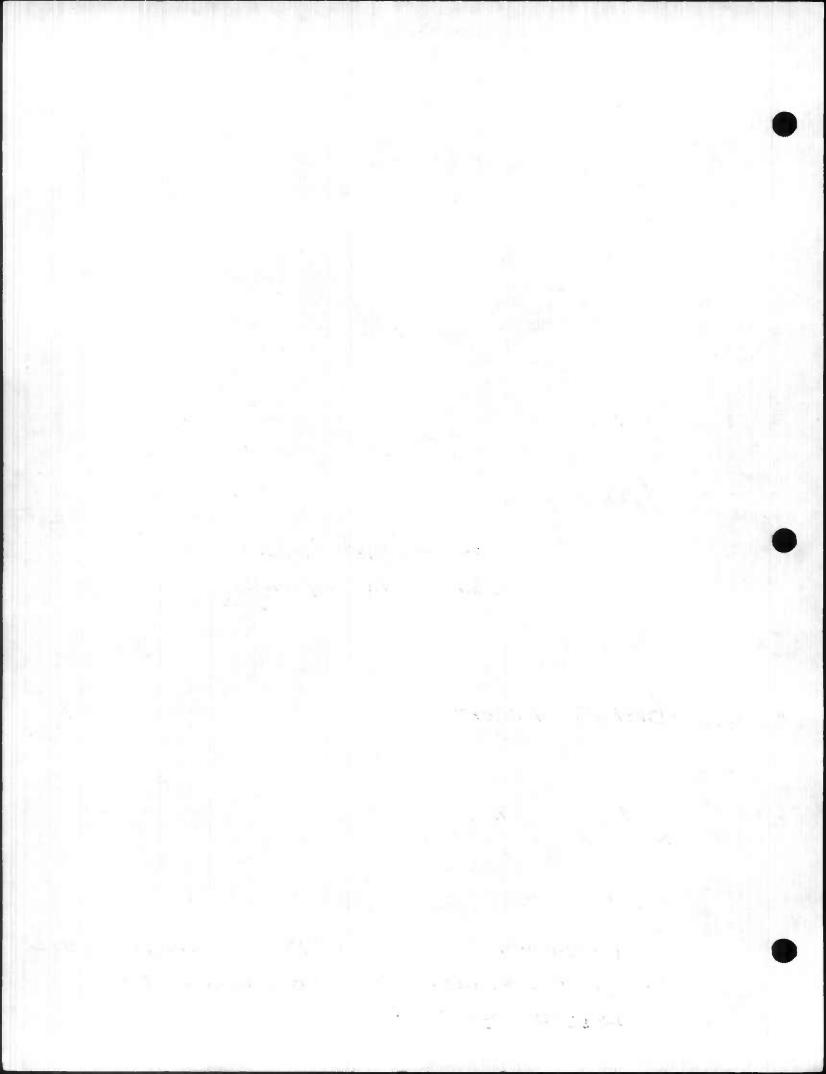
D27860 JANUARY 18, 2000

State Registrar

CHRISTOPHER

cause of death (Item, 23a) (Type, Print) KEARNEY 70 700 WASHBIND BALT MD 21230

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Larry Harding Wilson 28, 2000 January 10:38AM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital at Easton Easton, Talbot MD 6. Sex 1.XX/ 2□ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 19, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 218-48-8022 Maryland Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Dorchester Cambridge 1 Yes 3 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3623 Linkwood Drive 21613 US 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus Bleck, White, etc. 1 Never Merried 20 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Manufacturing Engineer Electronics Plant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elliott P. Wilson Shirley Harding 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Wilson 3623 Linkwood Drive Cambridge, Maryland 21613 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete 1XX Burial 2 ☐ Cremation 3 ☐ Removel from State MD Veterans Cemetery 2/1/2000 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility
Thomas Funeral Home, P.A. 21. Signeture of Funerel Service Licensee 700 Locust Street Cambridge, Maryland 21613 23a. Perty. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disaeae or condition resulting in deeth) tropen1a Due to (or as a donsequence of): Sequentially list conditions it any, leading to immediate

Division of Vital Records, P.O. Box 68760,

Examiner The law requires that the death certificate be executed physician s the burial 200 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

w 23a or must be r

21215-0020 Wilson

Baltimore, Maryland

Pages 1 and 2 should be fill ment of Health and Mental H tank: If Nem 27 is marked oth lury or other traumatic even

Physician

/Medical

cause. Enter Underlying Cause (Disease or Injury	chen	o Herap	4		10 days
that initieted events resulting in death) Lest	0	or es a consequence of):	can	cer	170
Part II. Other aignificant conditions con	ntributing to death but not re-	sulting In the underlying ca	usa given in Part I.	23b. Did tobacco use co	ontribute to the cause of death?
				24a. Wes an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner?	lospitel: 1 Impatient 2	ER/Outpatient 3 DO/	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Ott	her (Specify)
27. Menner of Death 1 DNetural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lajury M	Ic. Injury at Work?	28d. Describe how injury occur	rred
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	come, ferm, street, fectory,	office	281. Location (Street and Numi City or Town, State)	ber or Rural Route Number,
29e. Certifier (Check only one)	sician: To the best of my knoner: On the basis of examine and manner stated.	owledge, death occurred e etion and/or investigation,	t the time, date and placin my opinion, death occ	ce, end due to the cause(s) end m curred at the time, date end plece,	anner as stated. and due to the cause(s)
29b. Signature and fittle of certifiar	~	29c.	License number	29d. Date signe	ed (Month, Day, Year)
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DHMH 16 Rev 6/95

State

Registrar

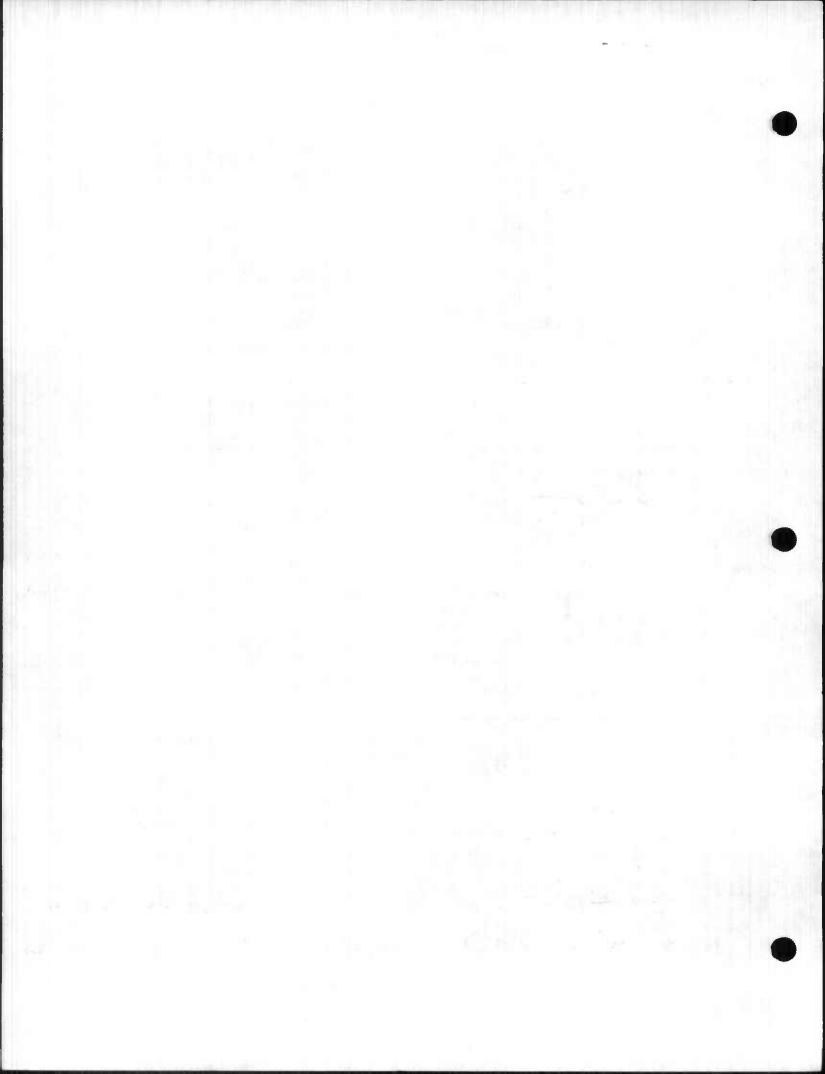
Peter Whitesell, MD 508 Idlewild Avenue Easton, Maryland 21601

32. Registfer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 3 1 2000

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 04646 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Yaai Hepsie Anne Burdette Williams 25,2000 Jan. 2:04 PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Undar 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yaar 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Days 1 M 2 X F Months 215-38-4045 88 26, 1911 Maryland Usual Rasidance of Dacedani 10c. City, Town or Location 10b. County t0d. Inside City Limits 1 Yas 2 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 U.S.A. 26533 Ridge Road

Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.)

Miranda

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

43 Harmony Hall Road, Gaithersburg, Maryland

18. Mothar's Nama (First, Middle, Meiden Sumama)

Drive, Mount Airy, Md. 21771

Etchison

1 Yas 2 No Specify:

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)

Homemaker

14. Race - Amarican Indian, Black, Whita, atc.

Own Home

20877

Specify: White

16b. Kind of Business/Industry

12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:

Coitaga (1-4or 5+)

Burdette

r 28a-f show inotified at the Maryla. b munt be. "natural", or hems 23s Demil. Pages 1 and 2 should be fled within 72 hours after Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or the Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

10a, Stata

11. Marital Status

1 Nevar Married 2 Married

15. Decedant's Education (Specify only highast grada complated)

W.

Charles O. Raines - grandson

Ronald E. Miller, M.D.

3 ☑ Widowed 4 ☐ Divorced

Elemantary/Secondary (0-12)

17. Father's Nama (First, Middle, Last)

James

19a. Informant's Name/Retationship (Type, Print)

Directo

Funeral

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Completed

Be

2

Funeral

Director

Physician /Medical Examiner

The law requires that the death certificate be executed

the

Division of Vital Records, P.O. Box 68760,

Examiner attending physician and for use as the burial-transit by Physician/Medical 80 signed by t Completed To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certific: completely filled in by the funeral director, Be Medicai Certification: To

20a. Method of Disposition		20b. Place of Disposition cematary, crametor			Data	20c. Location -	City or Town,	Stata
1 ☐ Buriat 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		Damascus Me		Cemeter	y 1/29	/2000 Dat	mascus,	Marylan
21. Signatura of Funarat Sarvice Licer	Noley at	7/ 01i		esworth		Funeral		20872-01
23e. Part1. Enter the diseese, or com shock, or haart failura. List only	plicetions thet causad to one cause on each line	ha daath. Do not enter the					App	roximate rvat Between sat and Death
tmmediate Cause (Finel disaasa or condition	· HEART	FAILURE					mo	UTHS 676A
resulting in death)		ua to (or as a consequand						
	D. AORTI	C STANO	5875				:46	ARS
Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Cause (Disease or injury	D	ua to (or as a consequenc	e of):					
that initiated avants rasulting in death) Last	C	ua to (or as a consequenc	e of):				i	N. 21
	d.							
Part II. Other algorificant conditions of RESPIRA		4	ying causa givan	in Part I.		d tobacco uas co ☐ Yas ★☐ No		cause of death?
	/					as en autopsy formed?	availab	utopsy findings a prior to tion of cause 1?
					10	Yes 25 No	1 □ Ya:	2 No
25. Was casa refarred to medical axaminar?			2	6. Ptece of Dee	th (Check only	one)		
1 ☐ Yes 2 No	Hospitai:	t 2 ER/Outpatient 3	DOA Other:	4 Nursing Ho	oma 5 Ra	sidence 6 Oth	ar (Specify)	
7. Mennar of Death 1 Natural 5 Pending 2 Accident invastigation		Year) 28b. Tima of Injury	28c. Injury a Work? 1 1 Ya	s 2 No	28d. Describ	e how injury occur	red	
3 Suicida 6 Could not be datermined		y - At homa, farm, straat, f (Specify)	actory, offica		28f. Location City or 7	(Street and Numb own, Stata)	per or Rural Ro	uta Number,
29a. Cartifier (Check only one) 12 Certifying Ph. 2 Medical Exam	ysicfan: To the best of niner: On tha basis of a and mannar state	my knowledga, daath occ xaminetion and/or investiged.	urred at tha tima, lation, in my opin	data and place, on, death occur	and dua to the	e cause(s) and mo a, data and ptaca,	enner as stated and dua to tha	cause(s)
96. Signature and title of certifier	- 1		29c. Licensa n	umber		29d. Data signe	d (Month, Day,	Year)
) Jelle	Co M	1	D2649	9		Jan. 2	6,2000	
30. Name and addrass of person who	completed cause of dea	ath (Item 23a) (Type, Print					717	

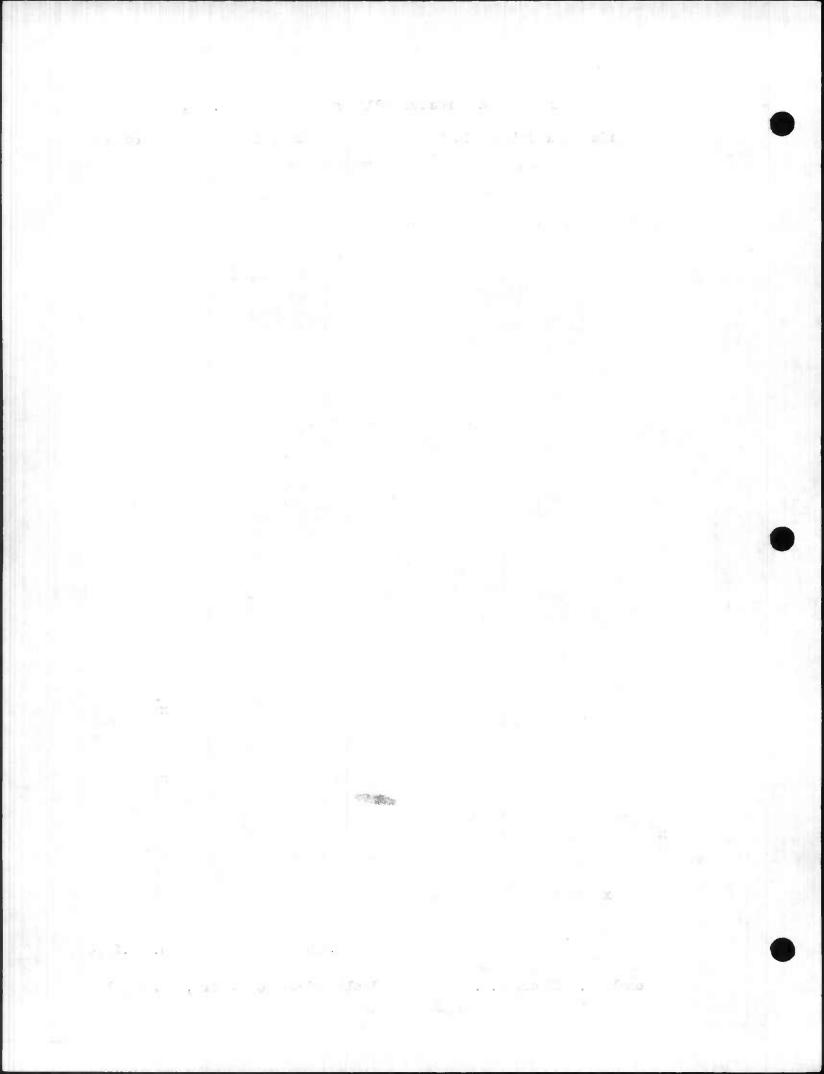
State

Registrar

32. Registrer Signatura

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4 Culwell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month **Physician** Betty Jane White January 24,2000 6:47 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital 8. Date of Birth Month, Gay Year 1938 Mary Land 5. Social Security Number 7. Age (In yrs. last birthdey) 61 Yrs. Birthplace (State or Foreign Country) **Funeral** Days 1□M 20 F Hours 212-38-4884 Director Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show Mt. Airy Maryland Frederick 1 Yes 2 No Director the Medical Examiner must be notifie 10s. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23s or U.S.A. 21771 12606 Old National Pike Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Deli Worker Super Market 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be find and Mental H Hamilton Catherine Rhodes Nettie Car1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12606 Old National Pike, Mt. Airy, Md. 21771 19a. Informant's Name/Relationship (Type, Print) rand 2 modernment of Health as important: if Item 27 is n any injury or other conce. Mr. William G. White, Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other placa)

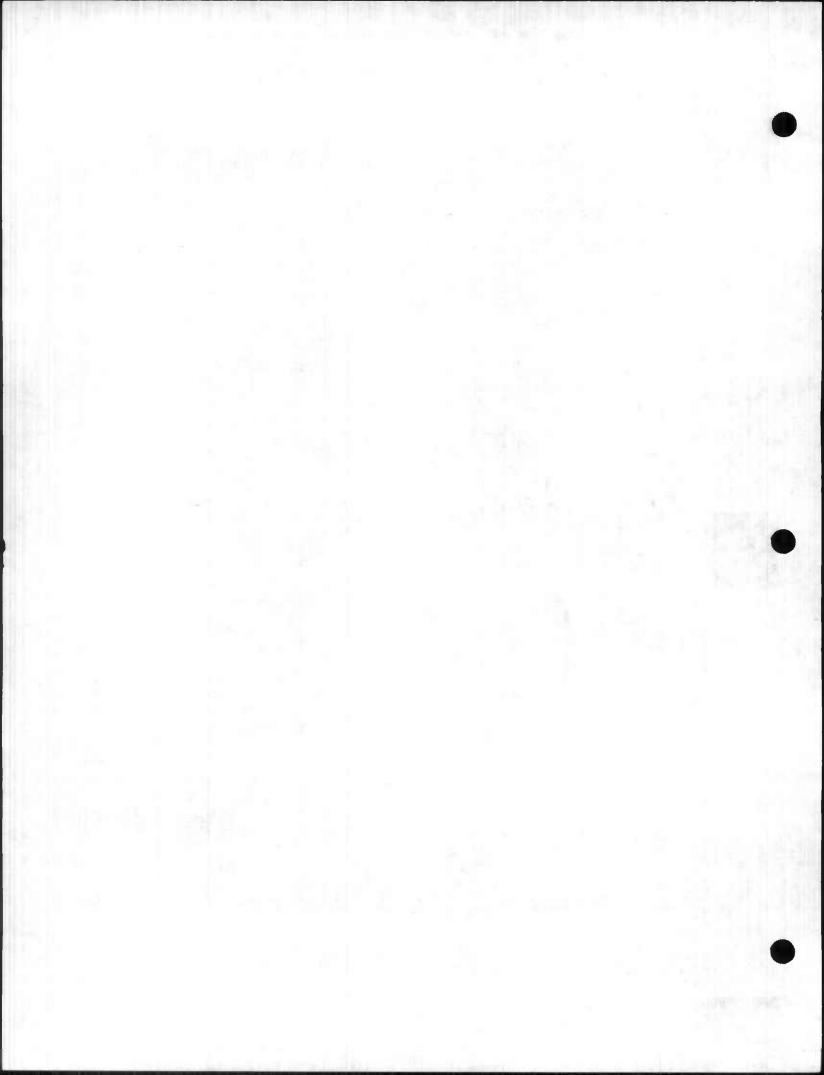
Resthaven Memorial Gandens, Jan. 27, 2000 20a. Method of Disposition
XX Burial 2 Cremetion 3 Removel from State 20c. Location - City or Town, State Frederick, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford PA Funeral Home MO0255 ruc 21701 106 East Church St., Frederick, Md. and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one clause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yaa 2 ☐ No 3 Probably 4 Unknown signed I Division of Vital Records, Completed by 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 No 1 Yes this certificate ooptial or Attending Physician: Theoris after death.
Inversi Director: After this certificately filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Manner of Deal 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifies 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nelenia (710 316 MA

Registrar **DHMH 16 Rev 6/95**

State

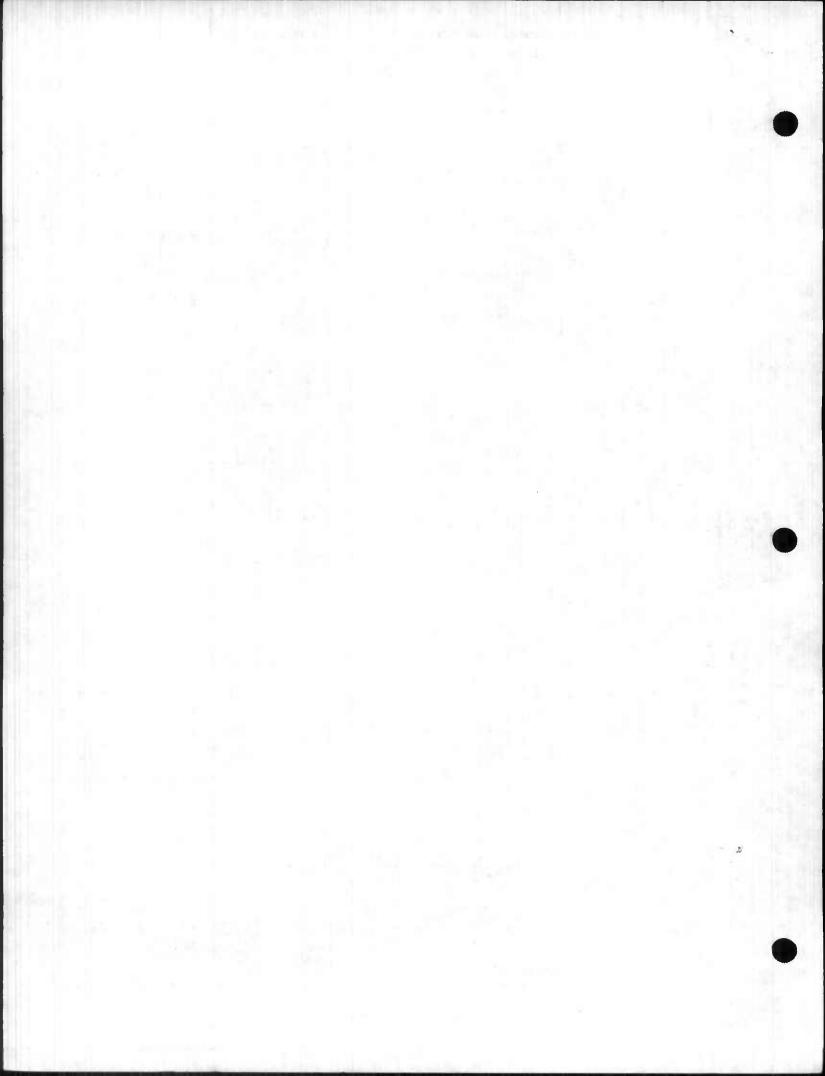
32. Registrer Signature

7 2000 **•**



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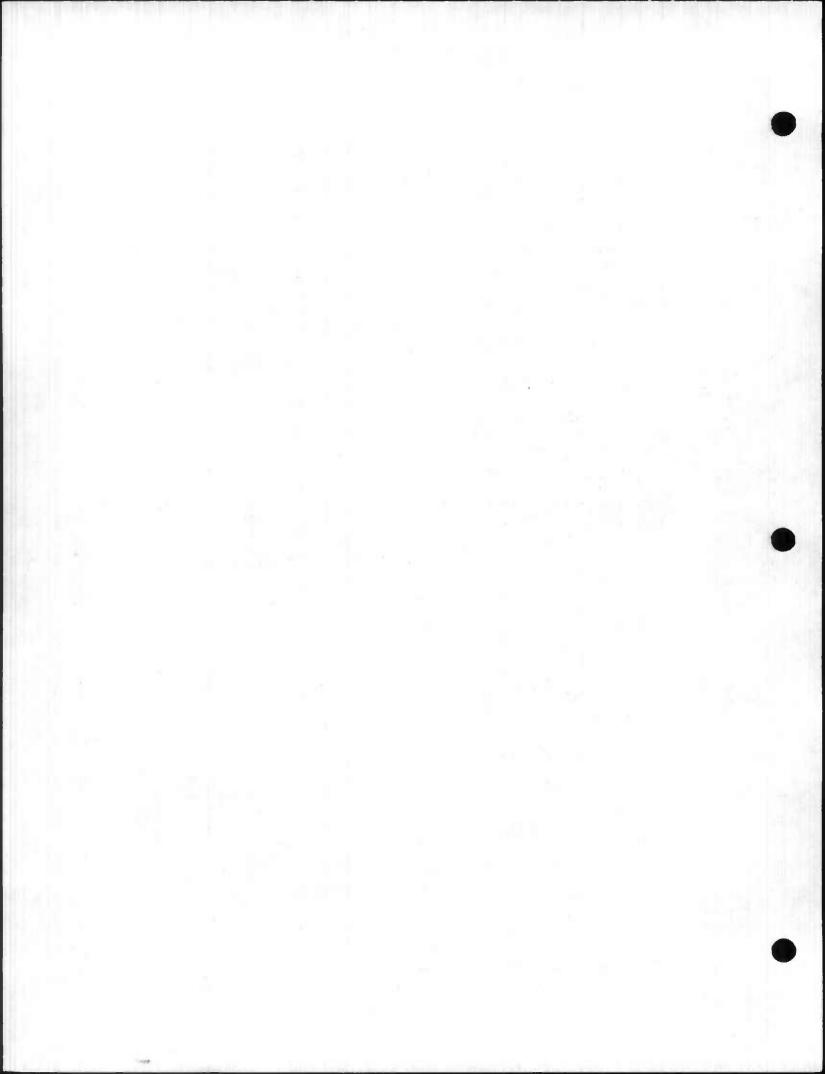
mended item#20b, 1 Decedent's Name (First, Middle, La: Harry Benjam a Facility Name (If not institution, given GREATER LAUREL) Cocial Security Number 6. Security Number 264-74-8603 Isual Residence of Decedent 0a. State 10b. County Maryland Montgom 0e. Street and Number	in White, we street and number) HOSPITAL Sex 7. Age (In yrs	II				2. Date of Dea Month	th Day	3. Time				
a Facility Name (If not institution, given GREATER LAUREL 1. Social Security Number 6. S 264-74-8603 Isual Residence of Decedent 10b. County Maryland Montgome	re street and number) HOSPITAL Sex 7. Age (In yrs						Day		of Death			
GREATER LAUREL 1 . Social Security Number 6. S 264-74-8603 . State 10b. County Maryland Montgome	HOSPITAL Sex 7. Age (In yrs 5	lest hirthday)				JANUARY	21, 20		30 PM			
. Social Security Number 6. S 264-74-8603 1 Suel Residence of Decedent 1 0a. State 10b. County	Sex 7. Age (In yrs 5	lest hirthday)		4	lb. City, Town, or	Location of Death	4c. County					
264-74-8603 Suel Residence of Decedent 100. County 100. Maryland 100. Montgome 100. 100	1\\ M 2□ F 5	lest hirthday)			LAUREL		PRINC	CE GEORGES	3			
Isual Residence of Decedent Oa. State 100. County Maryland Montgom	· ,	ast birtirody)	If Under Months		If Under 24 Hrs Hours Min	O. Date of City	Vend	9. Birthplace (State Country)	or Foreign			
On. State 10b. County Maryland Montgom		6 Yrs.	MOHITS	Days	Flours Mills	March 3	1943	Washingto	on, D.			
Maryland Montgom		- T										
	10c. C	ity, Town or Lo	cation					10d. Inside	City Limits			
0e. Street and Number	ery Ro	ckvill.	e					**	5 2 1140			
			10f. Zip	Code		1	0g. Citizen of V	What Country?				
1610 Burris Road				851				States				
1. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S. 13. \	Was Deced	dent of Ho	ispanic Origin? (S In, Mexican, Puer	Specify Yes or No- to Rican, etc.)						
41	1 ☐ Yes 2 ☒ No If Yes, Give	,	1 ☐ Yes	2X No	Specify:		Specify					
			-									
		(Give	kind of wo	rk done	during most of wa	rking	16b. Kind of Bu	usiness/Industry				
Elementary/Secondary (0-12)	College (1-4or 5+)						Marriana					
	-	Furni	ture	Move		me (First Middle						
		200 244 100		10:			-					
					Rd., Mt.							
		cemetery, cren	natory or o	ther plac	(e)		20c. Location - City or Town, State					
4 Donation 5 Other (Specify) Pine Grove Cemetery 1/26/00 Mt. Airy, M												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as e consequence of):												
	d											
art II. Other algnificant conditions o	contributing to death but not re	sulting in the ur	nderlying o	ause grv	en in Part I.							
						ישי	88 2LINO	3 Probably	Devinion			
						24a. Was a parfor	an autopsy med?	available prid	orto			
						188	es 2 No	1 Yes 2	□No			
					26. Piece of Do	eth (Check only o		7.5.5				
5. Was case referred to medicel	Hospitel: 1 ☐ Inpatient 20	ER/Outpatien	3 7 7	Oth	er.			er (Specifu)				
examiner?		28b. Time of		28c. Injur Wor	y at k?	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred						
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	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12) 12 7. Father's Name (First, Middle, Last Harry Benjamin W 19a. Informant's Neme/Reletionship (19a) 19a. Informant's Neme/Reletionship (19a) 19b. Method of Disposition 1 M Burial 2 Cremation 3 C 1 Donation 5 Other (Special Signature of Funeral Service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 23a. Part Enter the disease, or companded to the service Lieu 25a. Part Enter the disease, or companded to the service Lieu 25a. Part Enter the disease, or companded to the service Lieu 25a. Part Enter the disease, or companded to the service Lieu 25a. Part Enter the disease, or companded to the service Lieu 25a. Part Enter the disease, or companded to the service Lieu 25a. Part Enter Underlying Lieu 25a. Part E	Amed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 7. Father's Name (First, Middle, Last) Harry Benjamin White, Sr. 19a. Informant's Neme/Reletionship (Type, Print) Judy White / sister 10a. Method of Disposition 1 Marry Benjamin Sarvice Liberate 1 Donation 5 Other (Specify) 1 Signature of Funeral Sarvice Liberate 23a. Part Enter the disease, or complications that daused that shock, or heart failure. List only one cause on each line. Tommediate Cause (Final lisease or conditions, any, leading to immediate ause. Enter Underlying hat initiated events esulting in death) Last Due to (d	1 Never Married 2 Married 3 Widowed 4 Divorced Hyes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decederity December 12 15c. Decedent's Education (Specify only highest grade completed) 16a. Decederity December 12 16a. Decederity December 12 16a. Decederity December 13 16a. Decederity December 14 16a. Decederity December 15c. Decederity December 16a. December 16a. Decederity December 16a. De	1 Never Married 2 Married 3 Widowed 4 Divorced 1 New Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 - Furniture 7. Father's Name (First, Middle, Last) Harry Benjamin White, Sr. 19a. Informant's Neme/Reletionship (Type, Print) 19b. Maiting Address 3798 Botel 10c. Method of Disposition 1 Denation 5 Other (Specify) 1 Donation 5 Other (Specify) 20b. Plece of Disposition (New Cemetery, crematory or completed) 21 Signature of Funeral Service Licenses 22 Name are Stauff 8 E. R 23a. Part. Enter the disease, or complications that daused that the shock, or heart failure. List only one cause on each line. 25 Due to (or as a consequence of): 26 Due to (or as a consequence of): 27 Due to (or as a consequence of): 28 Due to (or as a consequence of): 29 Due to (or as a consequence of): 29 Due to (or as a consequence of): 20 Due to (or as a consequence of): 29 Due to (or as a consequence of): 20 Due to (or as a consequence of):	1 Never Married 2 Married 3 Widowed 4 Divorced Pyes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Furniture Move Furniture Move (Give kind of work done life. Do Not use retired li	1 Never Married 2 Married 3 Widowed 4 Divorced Pyes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 - Furniture Mover 7. Father's Name (First, Middle, Last) Harry Benjamin White, Sr. Myrtle 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rid 3798 Boteler Rd., Mt. 10e. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Facility Funeral Facilit	Amed Forces 1 Yes 2 No 1 Yes 3 No 1 Yes 3 No 1 Yes 4 Yes, Give Year or Dates: 1 Yes 2 No Specify: 1 Yes 2 Yes Yes	1	Total Content Total Conten			



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death January 21, 2000 **Physician** Daisy Alberta Wood 6:50 pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Nursing Home of Frederick County Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Jan 04, 1897 5. Social Sacurity Number 6. Sex Birthplaca (Stata or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 103 Yrs. 215-26-0814 Virginia Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or flems 23s or 28s-f show Maryland Frederick Frederick 1 Nas 2 No Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Giva Year or Datas: 1 ☐ Navar Married 2 ☑ Married altimore. Maryland 21215-0020 1 ☐ Yes 2 DINo Specify: White Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry filed within Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is marked of Thomas Theodore Young Sarah Emma Evelvn Wood 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Sarah G. Darr/Daughter 501 Pearl Street, Frederick, Maryland 21701 20c. Location - City or Town, Stata 20b. Place of Disposition (Name of 20a. Mathod of Disposition Data lary, crematory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Smithsburg Crematory Jan 24,2000 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility
Keeney & Basford P.A. Funeral Home M00706 106 E Church Street, Frederick, Maryland 21701 23a. Part¹. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final rotes carlon rescala disens diseasa or condition rasulting in death) Examiner Examiner that the death certificate be assecuted Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disease or Injury that initiated avents rasulting in death) Last and Due to (or as a consequence of): physician Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No t ☐ Yes 2 ☐ No certificate Division of Vitai al or Attending Physician: To safter death. I Director: After this certificat 25. Was case referred to medical axaminar?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4☐ Nursing Homa 5☐ Rasidence 6 ☐ Other (Specify) Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannar of Beath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 BNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident invastigation 6 Could not be datermined 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homiclda To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b edical 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of confine why completed cause of death (Item 23a) (Type, Print) State Registrar

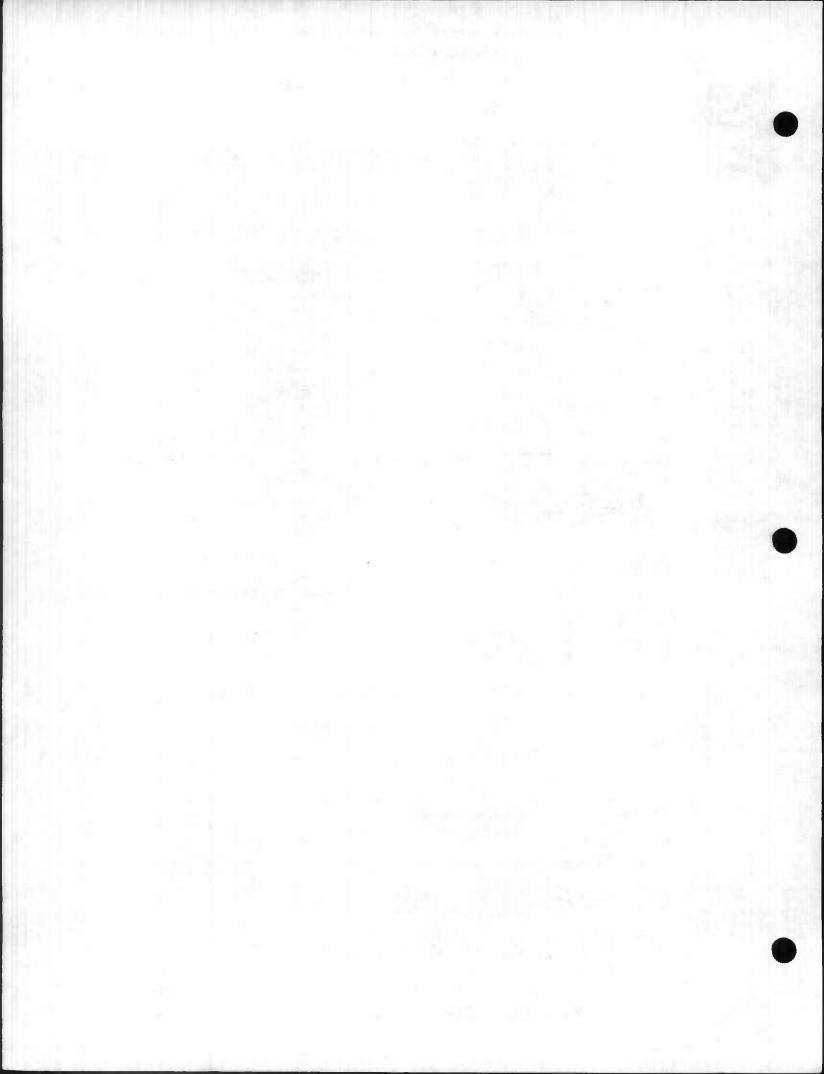


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Certificate of Death									Reg. No.			
ysician	1. Decedent's Nama (First, Middle, Last) Robert Wilson									2. Data of Dea Month	ith Day	Yaar	3. Time of De
Medical	Robert					January	-		11:29				
caminer	4a Facility Name (If not Insti Frederick Me		4	Fred		cation of Death		deric	le.				
and l	5. Sociel Security Number	6. Se		-	rs. last birthday) If Under	1 Yeer	If Undar 2		8. Date of Birtl	h		lace (State or F
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To Be Completed by Funeral Director	Usual Residence of Daceder 10a. State 10b. Co			100	City, Town or L	acetion							04 114- 01- 1
5		,	o.1.										0d. Inside City L
Directo	Maryland Fre	ederi	CK	F	rederic	K 10f. Zip	Code				10g. Citizen of	What Coun	try?
O	826 Chadwick	Circ	le				701				U.S.		
Funeral	11. Merital Status		12. Was De	cedant Evar in	n U,S. 13.	Was Deced	ent of Hi	ispanic Orig	gin? (Spe	ocify Yas or No-		ce - Americ	
F	1 Nevar Marriad 2		1 TYes	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give			If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yas 2 ☒ No Specify:				Specif	ck, White,	etc.
d D	3 □ Widowed 4 ▼ Divo		Year or									Whi	
Completed	15. Dec (Specify only h	edent's Edu ighast grad	ucetion de completed)	16a. Deci	6a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)			of worki	ng	16b. Kind of B	usiness/Inc	fustry
omp	Elementary/Secondary (0-	12)	College	(1-4or 5+)		y Equi					R.F. K	line	Co.
BeC	17. Fethar's Name (First, Mic	ddle, Last)				, -1					Meiden Sumer		
TOB	Ira T. Wilson	n						Myrt:	le G	ue		Mary Control	W
	19a. Informent's Neme/Rele					ling Address (Street and Number or Rural Route Number							
	Alice D. Allison (Friend) 826 Chadwick Circle, Frederick, Mar												
	20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State												
	A Donation 5 Other (Specify) Resthaven Mem. Gardens 1/25/00 Frederick, Maryland												
	ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701												
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DHMH 16 Rev 6/95

State Registrar Spark



If Under 1 Year

10f, Zip Code

21701

1 ☐ Yes XX No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Months

Days

8. Date of Birth (Month, Day, Year) Aug. 23, 1912

Aug.

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Mary Land

10g. Citizen of What Country? U.S.A.

14. Race - American Indian, Black, White, etc.

specify: White

16b. Kind of Business/Industry Electronics

If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene (04651 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wachter January 20, 2000 4:00 PM Herman Franklin /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 604 North Market Street Frederick

7. Age (In yrs. last birthday)

10c. City, Town or Location

Frederick

87

12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No

College (1-4or 5+)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day 1972) 4 2000 Flegistra's Signature

1♥M 2□ F

Funeral Director 5. Social Security Number

214-10-5288

10a. State

Director

Funeral

p

Maryland

10e. Street and Number

Usual Residence of Decedent

1 Never Married 2 Married

₩idowed 4 Divorced

Elementary/Secondary (0-12)

10b. County

Frederick

604 North Market Street

15. Decedent's Education (Specify only highest grade completed)

the Maryland **ehow** r than "natural", or Nama 23a or 28a-f ahor deeth

Pages 1 and 2 ahould be filed within 72 hours etter next of Hauth and Mertel Hygiene.
Intelf Ham 27 is marked other than "naturel; or the iry or other traumate event, me way as permit. Page Department of Important: If eny Injury or once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner physicien end the burial-transit that the death certificate be executed Box 68760 Physician/Medical 080 P.0. signed by the a Records, à Completed Division of Vital or Attending Physician: 8 Certification: To this funeral 24 hours after death.
Funerel Director: After the function of
Completed Manufacturing Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wachter Rose Engle Cornelius 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mrs. Janet G. Dinterman, Daughter 8716 Biggs Ford Road, Walkersville, Md. 21793 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 N Burial 2 ☐ Cremation 3 ☐ Removel from State Mount Olivet Cemetery, Jan. 24, 2000 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Licensee MO0255 chard 21701 106 East Church St., Frederick, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLERENCE CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Cithana OBSTRUCTIVE PULLARRY DISMSO 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? ATTIME FIBRILLATION completion of cause of death? 1□ Yes 25 No 1 ☐ Yes 2 ☐ No coron Cancer PROSTATE 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

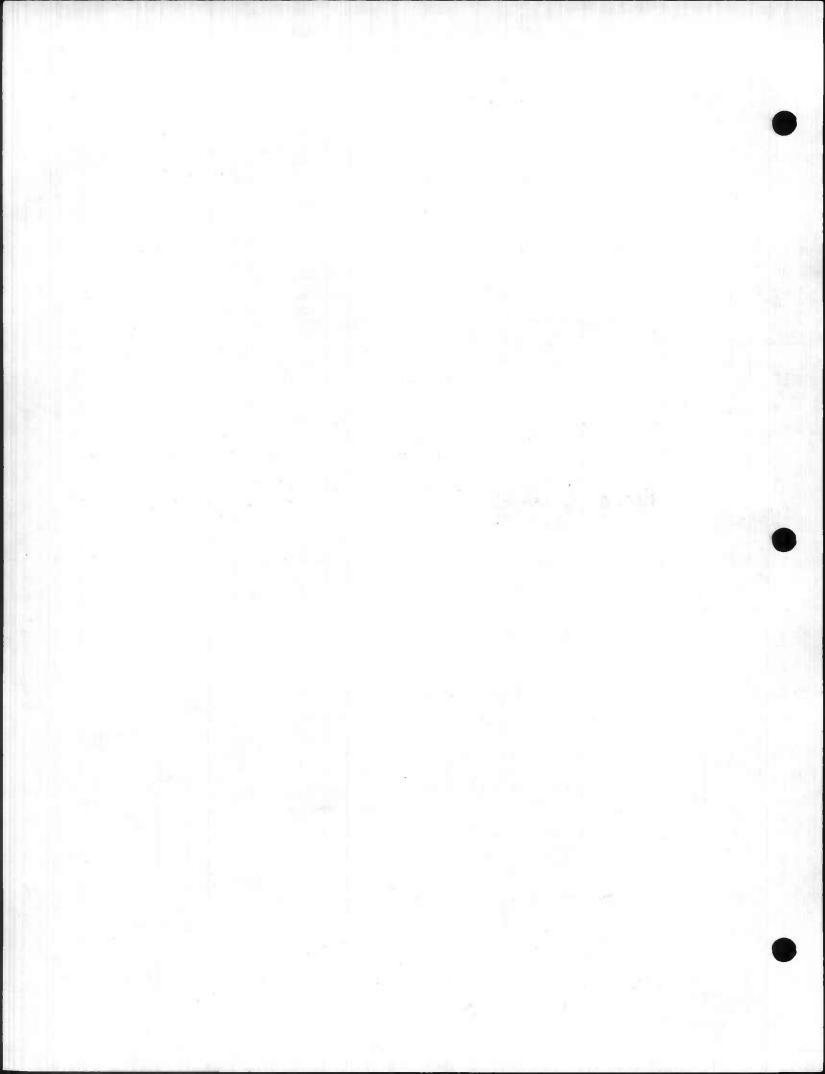
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and my inner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifia January 21, 2000 032171

State Registrar

Hospital

To the Hosp within 24 hox To the Fune completely fi

Richard L. Gough, M.D., 19 Frederick Street, Walkersville, Maryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 2 Day Winship 0204 Louise Sharon 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 1 M 20 F Months Days 59 214-38-8226 09/06/1940 Maryland Usual Residence of Deceden 10a. Stete 10b. County 10c City Town or Location 10d. Inside City Limits 1 Yes 2 No Princess Anne Somerset Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13439 Harrison Landing Road 21853 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Registered Nurse Medical 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Charles Milford Bell Louisa Filling 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip 20053 19e. Informent's Neme/Relationship (Type, Print) 13439 Harrison Landing Road, Princess Anne, Md. Edward Winship, Jr./ Husband 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Burial 2 Cramation 3 Removel from State 2/8/2000 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Olivet Cemetery 22. Name and Address of Facility Hinman Funeral Home Signature of Funeral Service Licensee-M00295 11673 Somerset Ave., Princess Anne, MD. Penti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearl feilure. List only one cause on each line. 21853 Approximete Interval Between Onset and Death anoxic BRAIN INJURY Immediate Ceuse (Finel disease or condition resulting in deeth) Ruspinatory arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that influence are or Injury) ANGIOEdema thet initieted events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 200 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Physician /Medical Examiner

Department of Health a important: If Item 27 is any injury or other tra once.

Baltimore,

Box 68760.

P.O.

Division of Vitai Records.

Physician

/Medical

Examiner

Funeral

Director

Nerne 23a or 28a-1 ahow ner must be notthed at

Pages 1 and 2 should be filled within 72 hours after do ment of Health and Montal Hyglene.

If them 27 is marked other than "natural", or from any or other traumatic event, the Medical Exercises.

Vinship

Director

Funeral

Completed by

The law requires that the death certificate be axecuted this After

Physician/Medicai þ Completed Certification: To Be

or Attending Physician: 24 hours after death.

Funeral Director: A filled in by Hospital Medicai within 2 95

25. Wes case referred to medical examiner? 1 Yes 25 No 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Deeth 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Cenymo

024872

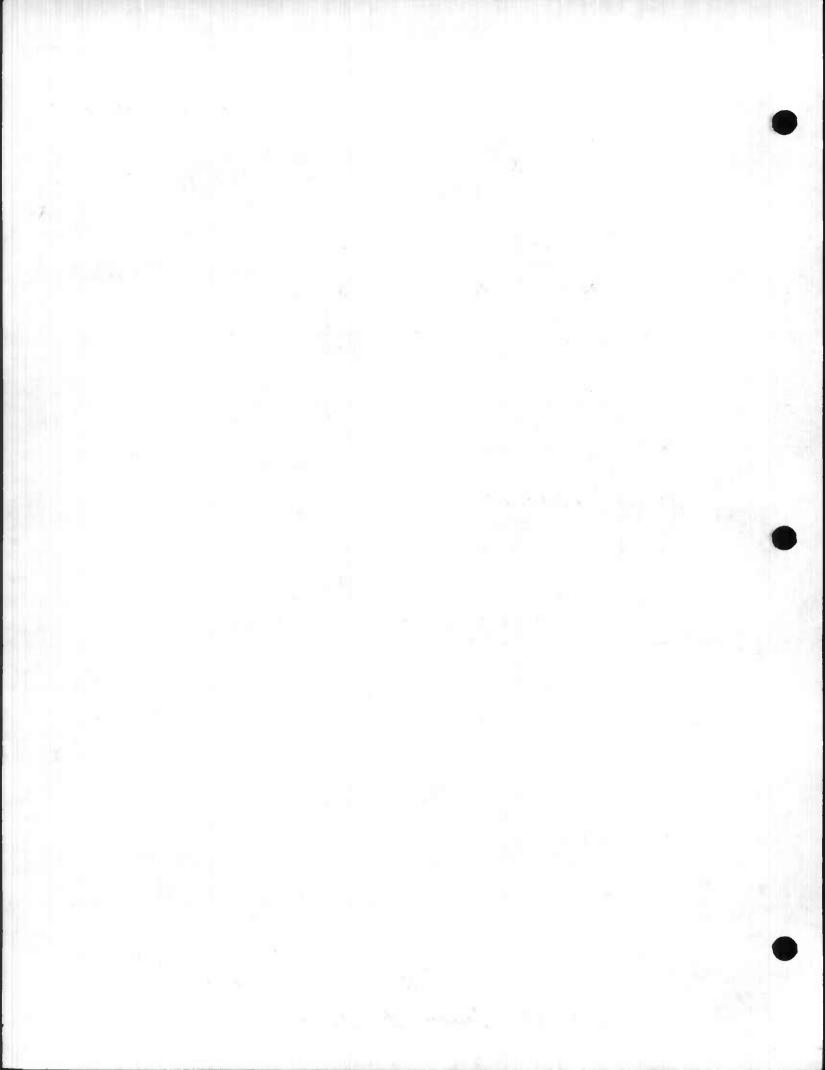
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salisbury md 21801 500 RIVERSIDE DR Fleury 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

FEB 0 7 2000





Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certi	ificate of	Death		Reg. No.) UL	653	
ľ			1. Decedent's Neme (First, Middle, La	ast)					2. Dete of De Month	ath	3.	Time of Death	
	Physic /Medi		Stanford			Whi	te			1, Day 200	O (0635	
	Exami		4e. Fecility Neme (If not Institution, git	ve street end number	-)			4b. City, Town, or I	ocation of Deeth	4c. County	of Deeth		
1			23000 Parkinso	n Road				Wenona		Som	erset		
602	Funeral Director		5. Social Security Number 6.3 218-16-9584 Usuel Residence of Decedent	Sex 7. A 1 M 2 □ F	ge (In yrs. las 89		If Under 1 Yeer Months Deys	If Under 24 Hrs.	8. Dete of Birt (Month, De 10/20/	h y, Year)		(State or Foreign	
	show abow		10e. Stete 10b. County		10c. City,	Town or Loca	tion					Inside City Limits	
	N o M	oto	Maryland Somerse	t	We	nona						1 ☐ Yes 2 No	
	23e or 2 ust be n	ral Director	10e. Street end Number 23000 Parkinson F	Road	10f. Zip Code ad 21821						10g. Citizen of Whet Country? USA		
020	72 hours after death with the Maryla hatural, or leans 23e or 28e-1 show ficel Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes:	2		es Decedent of I es, specify Cub	Hispenic Origin? (Spen, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Rec Bled	e - American Ir ck, White, etc.	ndlen,	
Maryland 21215-0020	ed within 72 hours ygiene. ser than "naturaf, it, the Medical Ex Completed by	pleted	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12)	ade completed)		16e. Deceder (Give kir life. DC	6e. Decedent's Usuel Occupation (Give kind of work done during m life. DO NOT use retired)		n ng most of working		usiness/Industr	у	
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ion	Attending Ph or death. ector: After th by the funeral	ation:	27. Manner of Deeth 1 Saturel 2 Accident 2 Accident	28e. Dete of Inj (Month, De	ury ay Year) 28	Bb. Time of Injury	28c. Inju Wo M 1	nyet urk?]Yes 2∐No	28d. Describe I	now injury occur	red		
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	To the Hospital or / within 24 hours efter To the Funeral Direct completely filled in the funeral filled filled in the funeral filled fil	edicai	29a. Certifier (Check only one) Certifying Property 2 Madical Example 1	nysician: To the best miner: On the besis of end manner s	of exeminetion	edge, deeth o	ccurred et the ti	me, date and plece opinion, deeth occur	, end due to the cred et the time,	ceuse(s) end me dete end piece,	enner es steted and due to the	l. ceuse(s)	
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				un H	pu	Jul	D30	C71.C		4/6	120	60	
			30. Name and address of person who DR. Benjamin Mey					y, MD. 21	804	/ /			
	Sta	ite	31. Dete filed (Month, Day, Year)		rer's Signetur		4	, ,	-				

DHMH 16 Rsv 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Mary 26, Webster 2000 Jan. 0500 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 10017 Levin Wilson Road Deal Island Somerset If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Yrs. Director 140-28-8764 62 02/21/1937 New Jersey Usual Residence of Decedent death with the Menyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Somerset Deal Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 10017 Levin Wilson Road "natural", or items 23s 21821 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mertel Hygiene. Int If Item 27 Is marked other than "natural; or ite nry or other traumatic avent, the Medical Engine. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) Elamantery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) George E. Hasher Anna Fithian 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jabez "Ting" Webster/Husband 10017 Levin Wilson Road, Deal Island, Md. 21821 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) St. Johns U. M. Cemetery 1/29/2000 Deal Island, Md. 21-Signature of Funeral Service Licensee 22. Name end Address of Facility Hinman Funeral Home Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical immedieta Cause (Final Myocardial infarction <12hk diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner CORONARY ARTERY 10475. DISCASE . physician end the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disaase or Injury that initiated evants resulting in deeth) Lest Dua to (or as a consequence of): CHRONIC OBSTRUCTIVE AIRWAY DISEASE P.O. Box 68760, Physician/Medicai Due to (or es a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown should be det Division of Vital Records, þ Completed 24a. Was an autopsy performed? 24b. Ware autopsy findings aveileble prior to completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Was cese rafarred to madicel exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending death. n 24 hours after death.

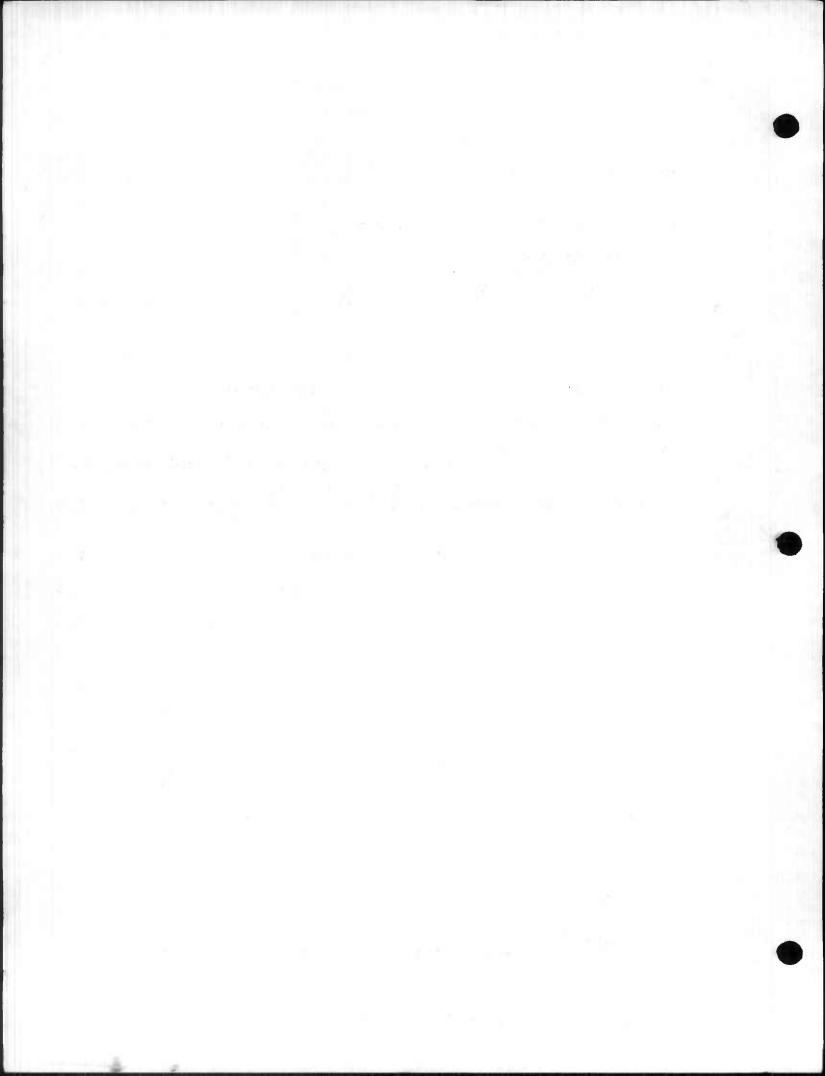
• Funeral Director: All pletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, daath occurred at the tima, date and place, and due to tha cause(s) and manner as stated.

2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DR. USHA NATESAN, M.D DO 51359 2000 30. Name and addrass of parson who complated causa of daath (item 23a) (Type, Print) DR. USHA NATESAN . M.D. 201 HALL HIGHWAY, CRISFIELD MD 21817 31. Data filad (Month, Day, Yaar) 32. Registrar's Signatura State

DHMH 16 Rav 6/95

Registrar

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 27, JANUARY 14:20 2000 MORRIS ABRAHAM YONKS /Medical 4a Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE
If Under 24 Hrs. 8, Date MONTGOMERY If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) **Funeral** Months Days 11 M 2□ F Yrs. Director 099.09.2700 Usuel Residence of Decedent 12.10.1908 POLAND 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 28s-f show 1 ☐ Yes 2 K No Director MONTGCMERY GAITHERSBURG MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 harra 23a 20877 101 ODENDHAL AVENUE USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indian, Bleck, White, etc. hours after 1 Never Merried 2 Merried 1 ☐ Yes if Yes, Gi No No altimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 TNo Specify: WHITE Specify: þ 3 ₩idowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) GARMENT PIECE WORKER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental is marked ISRAEL SOLOMON YABLONKA IDA YABLONKA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, informant's Neme/Reletionship (Type, Print) 6 OAK SHADE ROAD, GAITHERSBURG, MARYLAND 20878 HARRIET ROSEN/DAUGHTER mportant: If Item 27 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel trom State 4 ☐ Donetion 5 ☐ Other (Specify) 101.30.2000 PINELAWN, LI, NY NEW MONTEFIORE CEMETERY 21. Signeture of Funerel Septice Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical tmmediete Cause (Finei as disease or condition resulting in deeth) Examiner Examiner 21 buriel-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Box 68760 OCANDIZA Physician/Medical Due to (or as e conseque the 20 Chos 980 P.O. Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The law requires that signed t eumoni Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? 86 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 5 Pending of Funeral Director: Att pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29e. Certifier within 24 hor To the Fune completely fi (Check only onel To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oj -Maryland her 30. Neme and address of person who completed cause of death (Item 234) (Type, Print) 10 911 MO venue Gathersburg Russell Teven Ollosky

Registrar

State

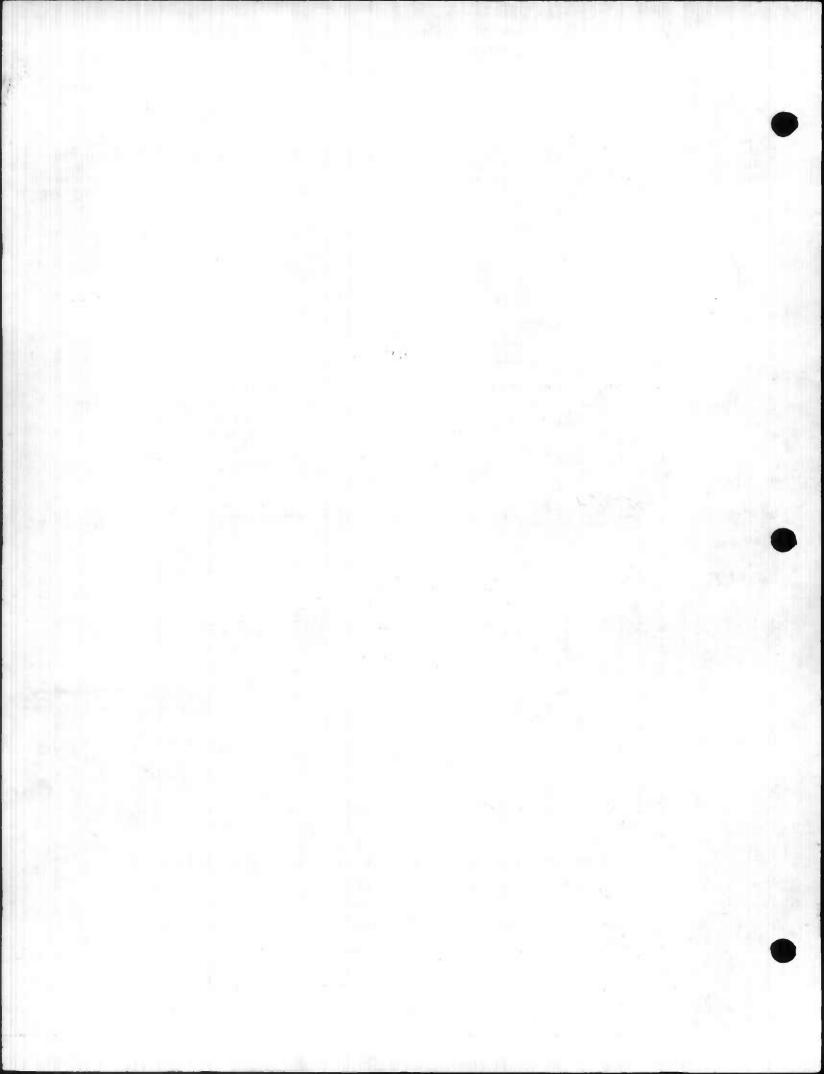
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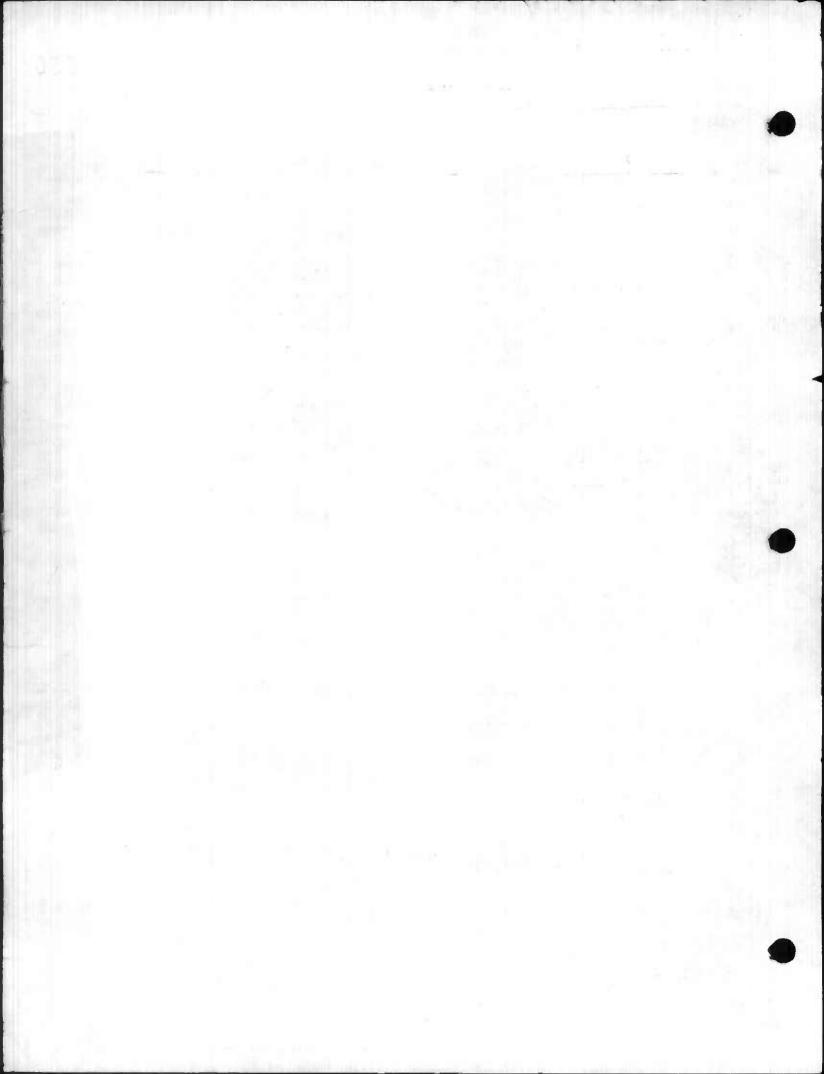
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Begistrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Winifred Berestore 4b. City, Town, or Location of Daath 4a Facility Name (If not institution, giva street and number) 4c. County of Death 6380 Open Flower Columbia, MD Howard If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1□ M 30 F 075-44-5832 83 Yrs. July 15, 1916 Guyana Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Columbia 1 ☐ Yas 30 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6380 Open Flower 21045 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yas 2 ☑ No if Yes, Give Yaar or Dates: 1 □ Nevar Married 2 □ Married 1 Yes 20€No Specify: Black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Cashier Dept. Store 18. Mother's Nama (First, Middla, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Johny E. Walker Suzan McMill 19b. Malting Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. tnformant's Name/Relationship (Type, Print) Janis McLennan / Daughter 6380 Open Flower, Columbia Maryland 21045 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rosehill Cemetery February 7, 4 ☐ Donation 5 ☐ Other (Specify) 2000 Linden, 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Nama and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 23a. Part I. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata tnterval Between Onset and Death Breast Immediata Cause (Final PSV disease or condition resulting to death) Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 TYAS 2 No 1 Yas 25. Was case referred to medical examiner? 28. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending

Physician /Medical Examiner Examiner

Physician

/Medical

MD

Director

Funeral

by

Completed

Examiner

Funeral

Director

item 27 is marked other than "natural", or itema 23e or 28e-f show other traumatic avent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traumatic avent.

Baltimore, Maryland 21215-0020

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Physician/Medicai

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Records, P.O. Box 68760,

Division of Vital

Hospital or Attending Physician: this funeral After after death. 24 hours a To the I

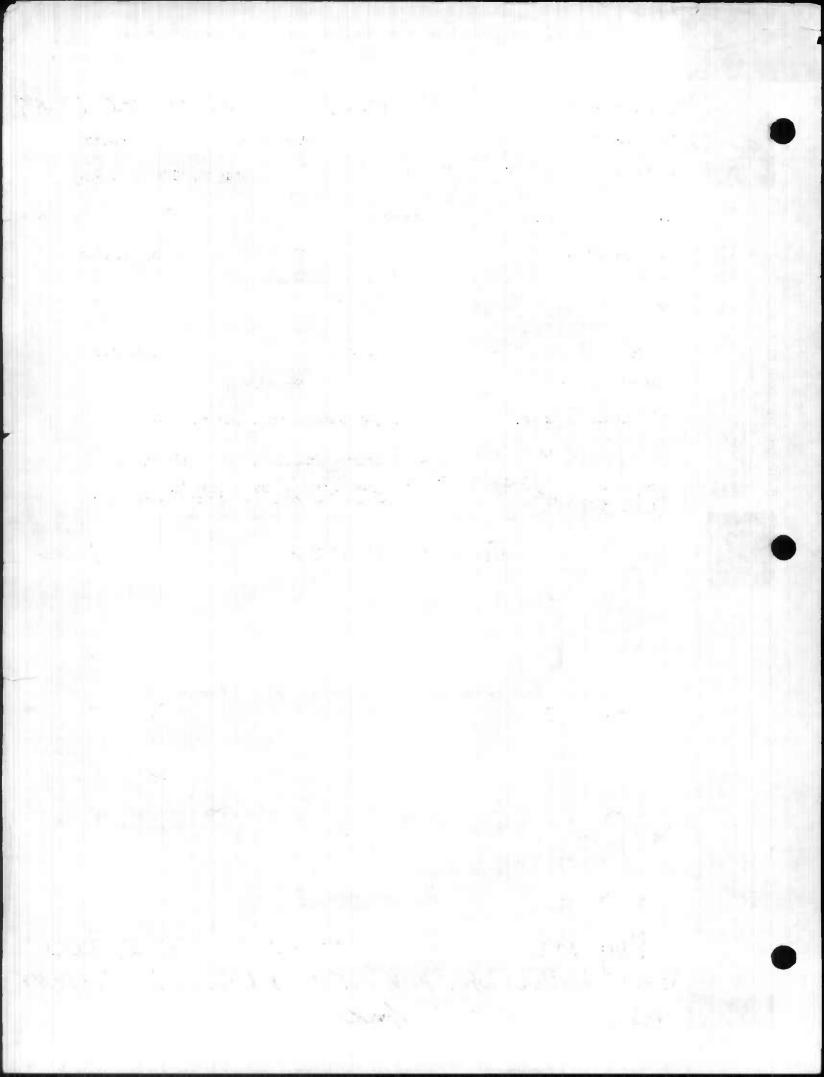
1-Natural 1 Yes 2 No investigation 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Certifian 🔁 Certifying Physician: To tha best of my knowledga, daath occurrad at the time, date and place, and due to the cause(s) and mannar as statad. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and titla of certile 29c. License number 29d. Date signed (Month, Day, Year)

CVOVC

se Rd Columbia Md 21045

State Registrar 31. Date filed (Month, Day, Year) 5 2000

32. Registrar's Signature

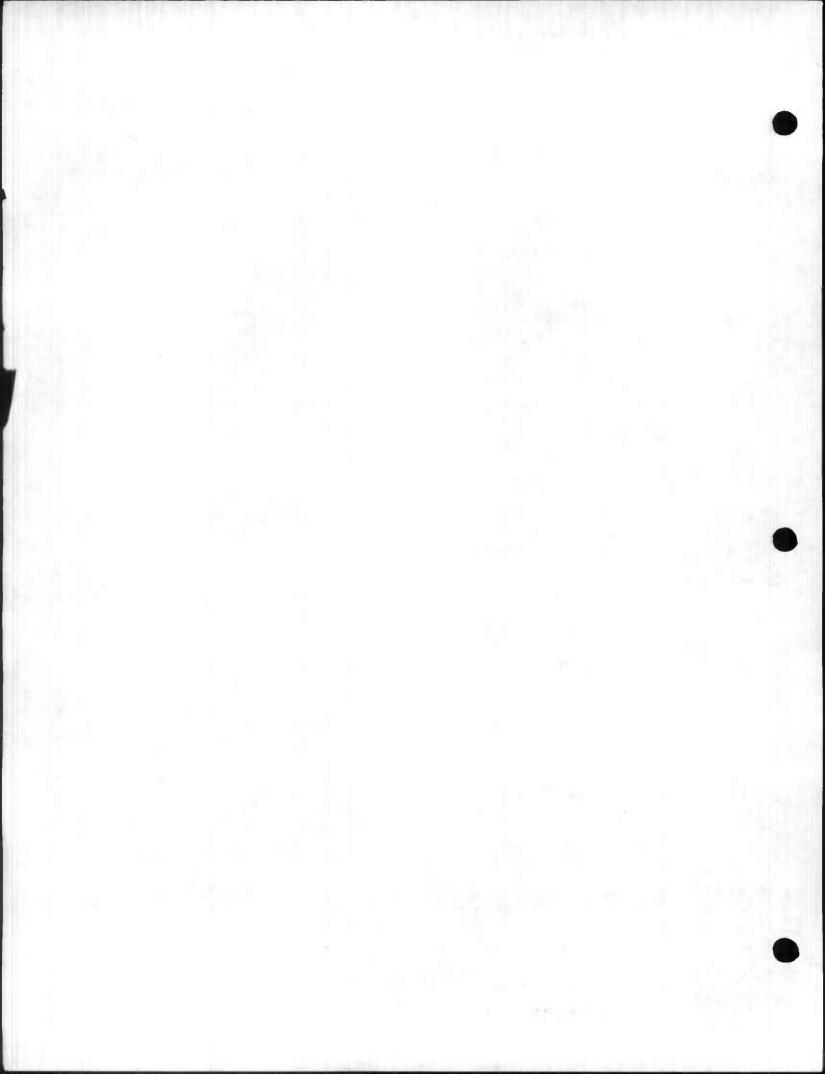


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State of Maryland / Department of Health and Mental Hygiene \(\cap \)

			Certific	cate of Death		Reg. No.	04030						
Dharaistan	1. Decedent's Nema (First, Middle, La	st)	12.10		2. Date of De Month		3. Time of Death						
Physician /Medical	Mildred Theresa	Brundick			FEBRUAR	,	000 12:50 F						
Examiner	4a Facility Name (If not Institution, giv	e street and number)		4b. City, Town,	or Location of Death								
	Saint Joseph	Medical C	enter	Tot	WSON	Ba	altimore						
Funeral Director		ex 7. Age (In 97		Inder 1 Year I II Under 24 I oths Days Hours A	Hrs. 8. Date of Bird Min. Feb. 9	y, Year) 9. 9 1903	Birthplace (State or Foreign Country) Maryland						
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or 28a-1 s be notified Director	MD Baltimo	re	Cockeysvi										
	300 International	Circle		f. Zip Code 21030		10g. Citizen of Wha							
72 hours after death vehicle 23 ficel Examiner must reed by Furneral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar Armed Forces? 1 Tyes 2 WNo If Yes, Give Yeer or Detes:		Decedent of Hispanic Origin's specify Cuban, Mexican, Press 2 DNNo Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Race - / Bieck, V	American Indian, Whita, etc. White						
d 2 should be filed within 72 hours at the and Merical Hygieron. The marked other than "natural", or traumatic event, the Medical Exams To Be Completed by F	15. Decedent's Ec (Specify only highest gra Elementery/Secondery (0-12)	lucation de completed) Coilege (1-4or 5+)	16a. Decedent's (Give kind o life. DO N	Usuai Occupation of work done during most of OT use retired)	working	16b. Kind of Busin	ess/Industry						
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To I	Charles Daniel S	mith		Ad	die Fletch	er							
da man	19e. Informant's Name/Reletionship (Type, Print)	19b. Meiling Ad	dress (Street and Number of	r Rural Route Numbe	er, City or Town, Sta	te, Zip Code)						
and and a	Genevieve B. Bu	usch/daughte	er 900-3 S	outherly Rd.	, Towson	, MD 212	04						
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Depa Impo any i ansa	22. Nama and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093												
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dea ed fo	Pert II. Other algolificant conditions co	ontributing to death but not	resulting in the underly	ing cause given in Part I.	23b. Did 1	lobacco use contril	buts to the cause of death						
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ifical or, p	25. Was case referred to medicai			26 Place of	Death (Check only o	/							
Physician: this certific ral director. TO Be (avaminar?	Hospitel:	2 C ED/Outpationt 2 C	Other			Considel						
D 0 0	27. Manner of Death	28a. Date of Injury (Month, Day Yea		28c. Injury at Work?	g Home 5 ☐ Resident Properties 1	now injury occurred	Specify)						
ding P the funer funer funer funer	1 Naturai 5 Pending 2 Accident investigation		r) Injury M	Work? 1 ☐ Yes 2 ☐ No									
To the Hospital or Attending Phyminin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	3 Suicide 6 Could not be determined		t home, farm, street, fa ecify)	ctory, office	28f. Location (S City or Tox		or Rural Route Number,						
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within To the comp	29b. Signatura and title of certifier			29c. License number		29d. Data signed (A	fonth, Dey, Year)						
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X	30. Neme and address of person who of JOGINDER MEHTE	·		DRIVE, TOW	VSON, MA	RYLAND E	21204						
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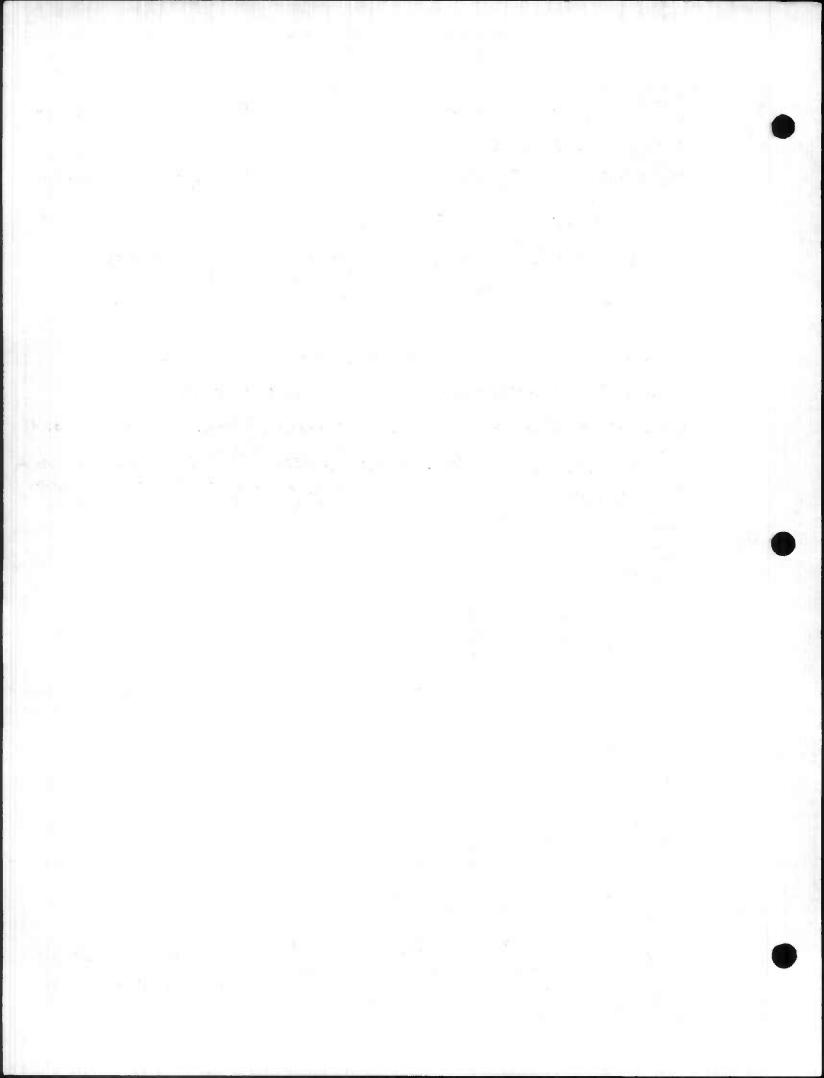
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State of Maryland / Department of Health and Mental Hygienen

				,		Certifica	ate of	Death	,	Reg. No.	046	559
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			1612 MicHalls	LOURT AF	7. Σ		1	FOREST H	141	HAR	FORD)
	Funeral			Sex 7. Age (In yr.	s. lest birth	dey) If Und	der 1 Year	If Under 24 Hrs Hours Min.	8. Dete of Bir (Month, Da	h Veerl		(State or Foreign
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	show a how	-				or Location						Inside City Limits
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	\$ 6 E	吉	10e. Street and Number			10f. :	Zip Code			10g. Citizen of V	What Country?	
	23 P	-	1612 (licHELLE	LOURT AP	7. 2.		210	020		V -	S.A.	
	s I end 2 should be filed within 72 hours after death with the Meryler Health and Mental Hygiene. It health and Mental Hygiene than "natural", or items 23a or 28af show then 27 is marked other than "natural", or items 23a or 28af show other traumstic event, the Medical Examiner must be notified at	Funeral Director	11. Meritel Stetus	12. Wes Decedent Ever in Armed Forces?	U,S.	13. Wes De	cedent of h	Hispenic Origin? (S en, Mexican, Puer	pecify Yes or No to Rican, etc.)	- 14. Rec	e - American Ir ck, White, etc.	ndian,
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5	72 h	Completed	15. Decedent'a E (Specify only highest gr	ducetion ade completed)	16e. C	Decedent's U	sual Occup work done	pation during most of wo d)	rking	16b. Kind of Bu	nalness/Industr	У
2121	filed within Hygiene. ther than	교	Elementery/Secondery (0-12)	College (1-4or 5+)	0		_	_		0 0		
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yle	should be nd Mental marked o	10		UNKILBIRGS	R			ALLB	MAY	HECKEN	RT	
Jar	2 sho		19e. Informent's Neme/Reletionship	(Type, Print)	19b.	Melling Addre	ess (Street	and Number or Ri	ural Route Numb	er, City or Town,	State, Zip Coo	le)
	Health Pm 27 Ither tr		BARBARA A. S	SUZVEL	125	36R		on Lour	ILAY T.	1,0072	ARYLA	100 a1047
Baltimore,	A Hora	0	20e. Method of Disposition 1⊠ Buriai 2 □ Cremetion 3 □		Plece of I cemetery	Disposition (A , cremetory o	Veme of or other ple	ce)	Dete Dete	20c. Location -	City or Town,	Stete
E	All Property and the second		4 Donation 5 Other (Speci		1/2 C	6 GRSS	28/03	METERY	FEB. 14, 2000	JAMP H	127 120	northeria
alt	emit. Pa opertmen nportant: ny injury 006.		21. Signator of Euneral Service Lice				end Addre	ess of Fecility	001 000	LAIR, F	2 A	01000
m	50 T F B					SVAC	5 Fur	ME STINE	かってー 173	T1/11/1		21050
	_		23e. Pert1. Enter the disease, or con shock, or heert feilure. List only	pplications that caused the dec	eth. Do no	ot enter the m	M PO	no, such es cardie	or respiratory a	THILL,	Apr	proximete
4	Physician		shock, or heart feilure. List only	one cause on each line.			,		,		Inte	erval Between set and Deeth
	/Medical		Immediate Cause (Finei	DOME	. 7	2001	10.	Λ			2	YEARS
	Examiner		disease or condition resulting in death)	· MYEL				1				Jenies
		9		Due to	(or es e co	nsequence o	or):				1	
	cate be asscuted physician end the burial-transit	Examiner	•	b			Λ.					
,	death certificate be axecuted e attending physician end of for use as the burial-transit	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a cc	ensequence o	и).				B	
68760,	sicia bur	Ca	Cause (Disease or injury thet initieted events	C.			۸.					
68	uficat g phy as th	Physician/Medical	resulting In deeth) Last	Due to (or es e co	nsequence o	F):					
Box	certifi nding use a	2		d		_						
B	thet the death cer ed by the attendir datached for use	cia	Death Other death, and an abuse									
0	y the	lys	Pert II. Other eignificant conditions of	contributing to death but not re	sulling in I	ne underlyln	g cause gh	ven in Pert I.		_/		cause of death?
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Records,	iaw requires that the es been signed by th 2 should be datache	d by							24s Was	en autopsy	24b Were a	autopsy findings
0	v requin	Completed							perfo	med?	availabl	ele prior to
360	hes i	ld I									of death	h?
=	Pag at a	S							10	res 25 No	1 🗆 Ye	s 2 No
Vital	Physician: The i this certificata he ral director, page	Be	25. Wes case referred to medical exeminer?						eth (Check only o	ne)		
of		ဥ	1 ☐ Yes 2189 No		☐ ER/Outp	atient 3	DOA Oth	ner: 4 Nursing H	lome 5129 Resid	dence 6 DOth	er (Specify)	
0	ng Ph ter thi neral		27. Menner of Death 12⊠Neturel 5 ☐ Pending	28a. Dete of injury (Month, Dey Year)	28b. Tir	me of ury	28c. Inju	ry at rk?	28d. Describe I	now injury occur	red	
.0	Attending Ph or deeth. ector: After thi by the funeral	atic	2 Accident Investigatio	n	·	М		Yes 2 □ No				
Division	Atte	tific	3 Suicide 6 Could not be determined		home, fem	n, street, fect	ory, office		28f. Location (S City or Tox	Street and Numb	er or Rural Ros	ute Number,
ō	s aft al Die od in	Certification:		bonding, old. (oped					ony or roo	, 0.0.0,		
	hour hour mer		29e. Certifier 15 Certifying Pt	nysician: To the best of my kn	owledge,	deeth occurre	ed et the ti	me, dete end plece	, and due to the	cause(s) end ma	inner as stated	1.
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edica		niner: On the besis of examinend menner steted.	etion end/	or mivestigeti	on, in my c	prinon, deeth occu	miled of the time,	nara aud biaca,	enti or euo prin	cause(S)
	with To t	×	29b. Signature and title of certifier	0		2	29c. Licens			29d. Dete signe	d (Month, Day,	Year)
	1		17 7 d 111	and.	m		231	1775	1	- FARLA	RVIL	2000
	8		30. Namy and address of person who	completed cause of deeth (Ite	m 23e) (T	ype, Print)		^		201101	10/17	
	0		£ ^	WARDS OLD) - AI	12 B.	LATR	ROAD	FALLSTA	MAR	MANO	SIDLE
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registrer's Bigr	neture			10.00	1 11000 10	111111	· · · · · · · · · · · · · · · · · · ·	010 11
	Di-tu		7 C C 1	5 2000 /200	when	14	1	10.101				



Nadine DeHaas Buck

1. Decedent's Name (First, Middle, Last)

Physician

Certificate of Death

04660

2000

3. Time of Death

210 an

Reg. No.

2. Date of Death Month

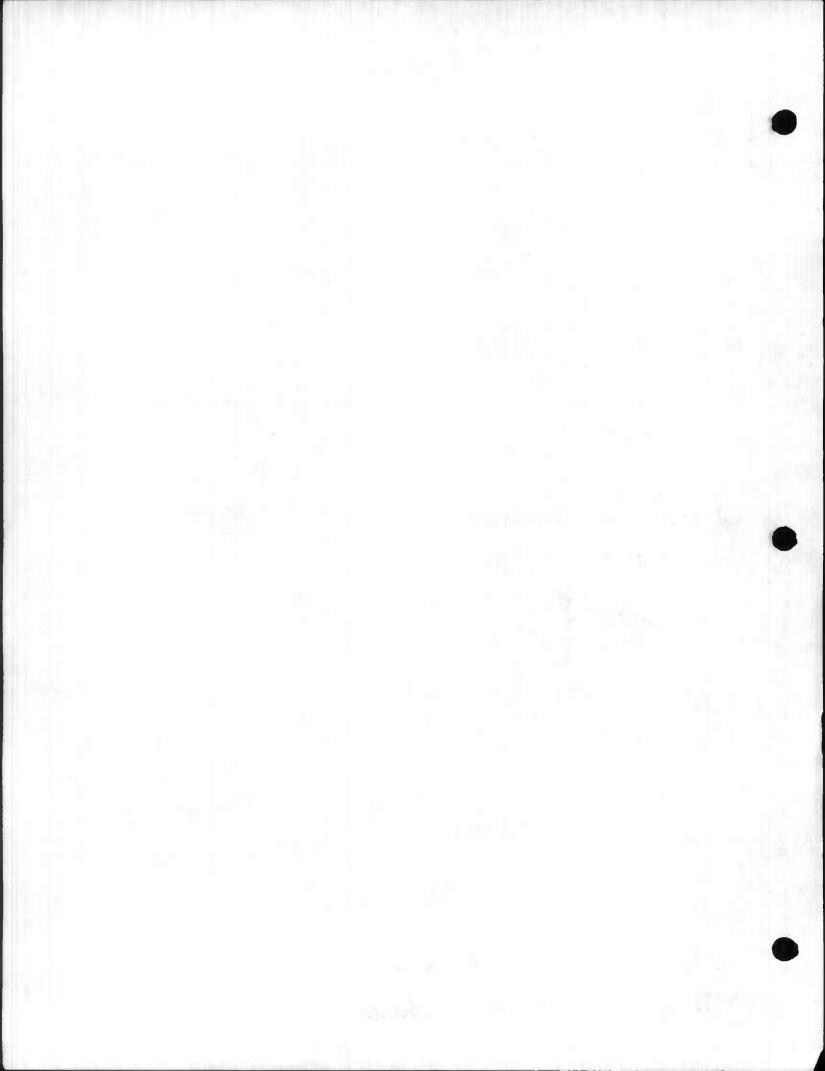
February 13

Examiner	4a Facility Name (If not institution, giv	re street and nu	imber)				4b. City, Town, o	or Location of Dec	th 4c. Count	y of Death	
	Franklin	square	Hospite	al ce	enter			Rosed	ale	Bal	Him	0re
Funeral Director	5. Social Security N 210-03	-7248 ¹	Sex IDM 25+F	7. Age (In	yrs. last birth	M	Under 1 Year onths Day	ar If Under 24 H		1, 1916	9. Birth Cou Penns	place (State or Foreig ntry) Sylvania
	Usual Residence of	f Decedent 10b. County		140	City Town	!						
28a-f shownorth and a factor		,		10c. City, Town or Location						10d. Inside City Limit:		
r tems 23s or 25s-f sho dost must be notified at Funeral Director	MD	Baltim	ore		White					1 Yes 2 1		
al Dir	10e. Street and Number 10f. Zip Code								10g. Citizen of		ntry?	
1 10	8810 M	alther	31vd. Broadview 1305 21234							USA		
a eur	11. Marital Status		12. Was Dec Armed F				f Hispanic Origin? - uban, Mexican, Pur	lo- 14. Race - American Indian, Bleck, White, etc.				
p À	3 X Widowed	ied 2 Married 4 Divorced	1 Tes If Yes, Gi Year or [ive A	No					Speci	Specify: White	
	(Spec	15. Decedent's Ed)	(0	Give kind	s Usual Occ	ne during most of w	16b. Kind of Business/Indus			dustry
Be Completed	Elementary/Second 1.2			1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired) Homemaker					Own	n Ho	me
To Be C	17. Father's Name	(First, Middle, Last,)			18. Mother's Name (First, Middle, I					me)	
10	В	rooke D	aHaas						Jean H	elfrich	1	
		ame/Relationship (Type, Print)		19b. N	Vailing A	ddress (Stre	et and Number or	Rural Route Num	ber, City or Town	n, State, Zij	o Code)
5	Michael	A. Buck/s	on		16	116	Carro	11 Road,	Monkton	MD 21	111	
	20a. Method of Dis	position			Ob. Place of D)ispositio	n (Name of		Date	20c. Location		own, Stata
Injury or		Cremation 3 5 Other (Specif		State	Metro Crematory or other				Baltimore, M		MD	
		menal Service Lices		4 1 4		22. Name and Address of Facility Cremation Society of Man						
Buce	- El	Jan. P.A. S	regordule Crem			emat	ion Soc	f Maryl	Inc.			
	Edwa		regord			29	99 Fr	ederick	Rd. Ba	altimor	e, M	Approximate
	23a. Part1. Enter t shock, or hea	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
ian												Onset and Death
cal ner	tmmediate Cause disease or condition resulting in death)	วัก	· Sepsis							Imonth		
	1 1000ttily in County		Due to (or as a consequence of):									
_ <u> </u>			h									
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
dical Examin	Cause (Disease or	erlying injury	c								i	(5)
용	that initiated event: resulting in death)			Due	to (or as a cor	nsequen	ce of):					
Physician/Medical			d								i	
ne												
/ Physic	Part II. Other signit	ficant conditions o	ontributing to d	eath but no	ot resulting in t	he under	tying cause	given in Part t.	23b. Di	d tobacco use co	ontribute t	o the cause of death
문	Renal	Ins	EFI	100	0001					Yes 210 No	3 Pro	bably 4 Unknow
ā	1561100		01-10	-161	1-A						T	
Completed by									24a. Wa	is an autopsy formed?	8/	Vere autopsy findings vailable prior to completion of cause
Comple				-								death?
5									10	Yes 2 40	1	Yes 2 No
Be	25. Was case refer	red to medical						26. Place of D	eath (Check only	r one)	1	
To Be	axaminer?	No	Hospital:	Inpatient	2 ER/Outp	atient 3	BD DOA	Other: 4 Nursing	Home 5□Re	sidence 6 🗆 Ot	ther (Speci	ify)
	27. Manner of Deat		28a. Date	of Injury	28b. Tin		28c. In	jury at	28d. Describ	e how injury occu	med	
Ş	1 DNatural 2 Accident	5 Pending investigation		ith, Day Ye	ar) Inju			Yes 2 No				
Medical Certification:	3 Suicide 4 Homicide	6 Could not be determined	286. Place	e of Injury - ing, etc. (S	At home, farm	n, street,	factory, offic	×e	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
completely filled in b	29a. Certifier (Check only	Cortifying Ph	yelclan: To the	best of my	y knowledge, d	seath occ	curred at the	time, date and pla	ce, and due to th	e cause(s) and m	nanner as s	stated.
P	one)	2 Medical Exam	and man	ner stated.	annation and/	or ativesti	yauton, in my	y upwirum, death oc	COTTOU AT THE TIME			
Σ	29b. Signature and	title of certifier					29c. Lice	nse number		29d. Date sign		
	1	M. On	1)			RD	19878		7-1	5-0	0
	30. Name and addr	ess of person who	completed caus	se of death	(Item 23a) (Tr	ype, Prin	0					
	DR Angel	a myles	9000 F	an Klin	n Squar	e D	rive e	saltimore	Marykan	J Z123	+	
C4-4-	31. Date filed (Mon			legistrar's S								

DHMH 16 Rev 6/95

Registrar

FEB 1 5 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Year **Physician** Q RILS DAI 7 トハ・フ 10 2002 2 10 /Medical 4b. City_Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** MJ Bezzu Salvo. Cin 1911 NA If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) | O1-04-50 5. Sociei Security Number 7. Age (1g/) 6 Sax Birthplace (State or Foreign Country) rs. last birthday) **Funeral** Months 216-54-4845 1√2 M 2□ F Yrs. Director MD Usuel Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2□No MD NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 1911 W. Mulberry Street Негия 23а 21223 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien, 11. Merital Stetus Bleck, White, etc. within 72 hours after 1 Nevar Merried 2 Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yas 2 ☐ Nio Specify: Specify: P Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 10th Grade Painter NA Various Company 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit, Peges 1 and 2 should be fill Department of Health end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event Be William Newton 2 Romaine Barksdale 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21223 Paulette Barksdale 1911 W. Mulberry Street baltimore, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from Stete Mt. Zion Cemetery 02-16-2000 Lansdowne, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 uneral Service Licensee WM.C. March FH 1101 E. North Avenue me deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final SUCCEST (Sucart. 20160 disaase or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in deeth) Last end Due to (or es a consequence of): physicien streets Box 68760. Physician/Medical Due to (or es e consequence of): 65 65 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. \$ signed by t 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed peeu completion of ceuse of death? 988 1 ☐ Yes 2 ☐ NO 1 Yes 2 No certificate Division of Vital 25. Was cese referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Anesidence 6 □Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation or Attending 11 Diraturai after death. Director: Aft d in by the lur 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 124 hours a Hospital 1 Sertifying Physician: To the best of my knewledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and megner stated. edical 29e, Certifier (Check only one) To the F within 2. To the F complet

State Registrar

DHMH 16 Rev 6/95

29b. Signature and title of certifier

31 Date filed (Month, Dey, Year)

nd address of person who

5

Du.

MC

pleted ceuse of death (item 23a) (Tybe, Pript

32. Registrer's Signeture

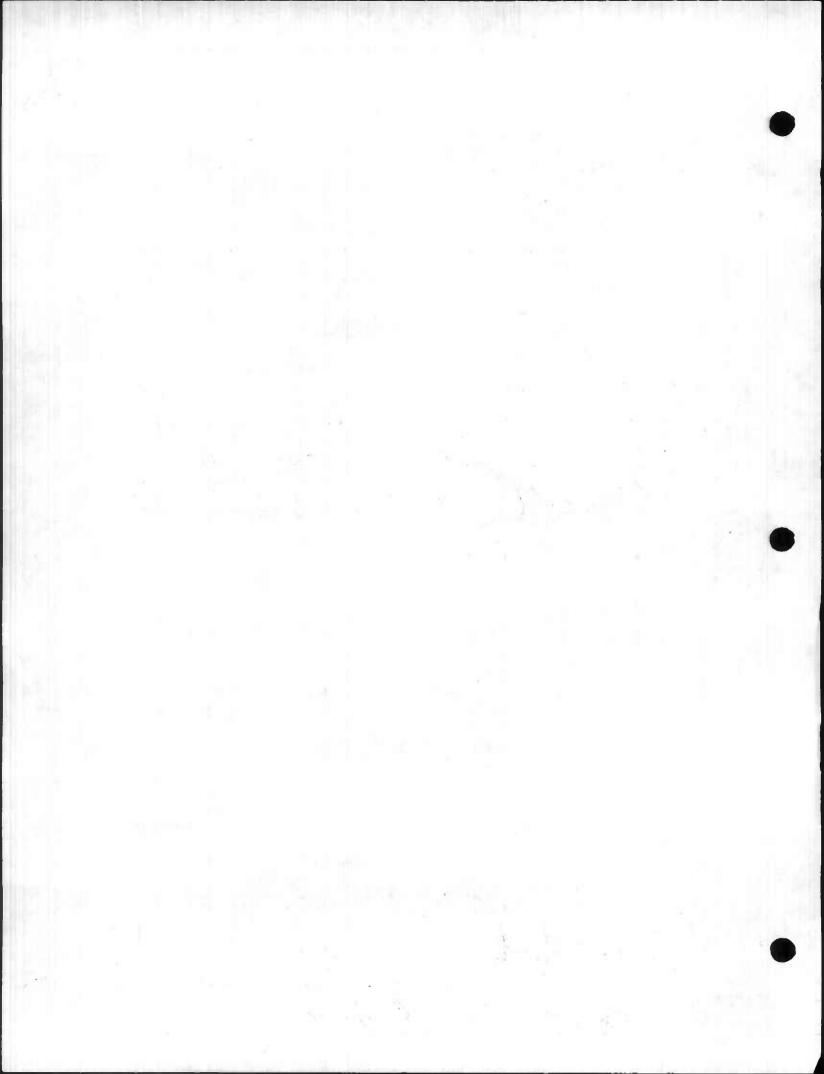
29c. License number

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29d. Data sign#d (Mo#th, Day, Year)

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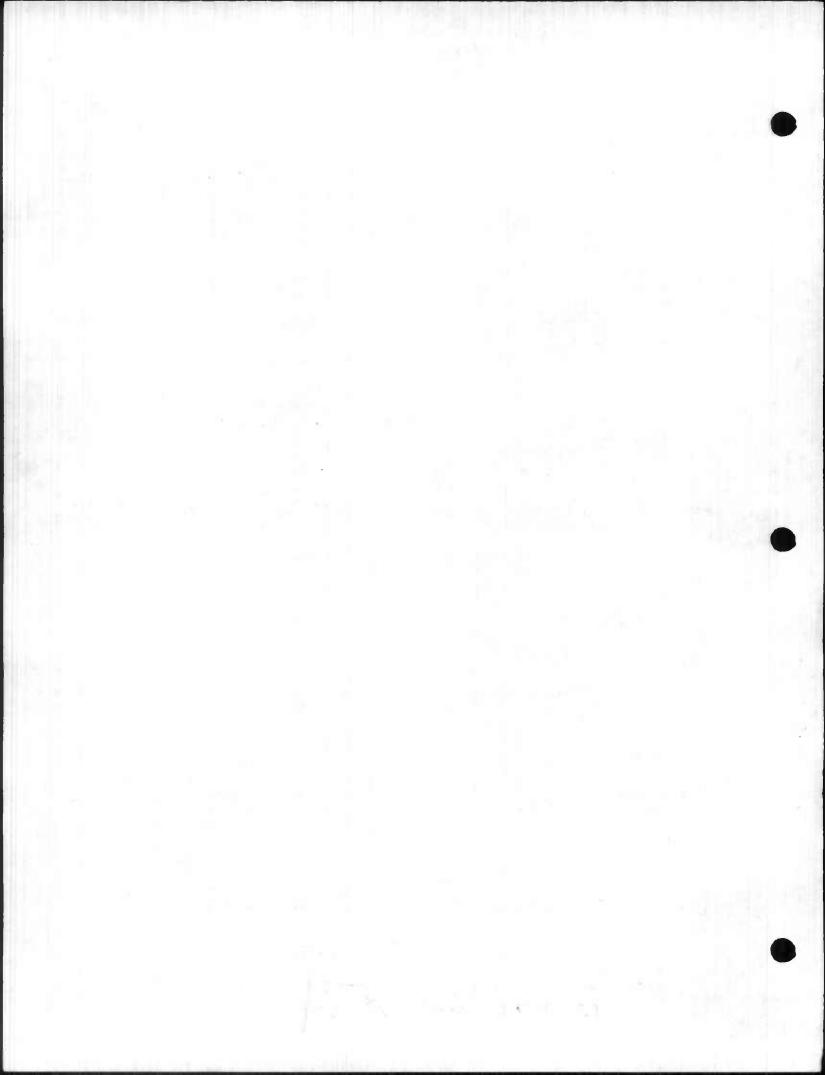


BROLL, WILHELMINA

NAME:

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Demousel from State	Plece of Dispo cemetery, crer	osition (Name of metory or other)	place)	Date 2	0c. Location -	City or Town, Stata	i					
4 Donation 5 Other (Specify) Parkwood Cemetery 2/12/2000 Baltimor												
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3331 Brehms Lane Baltimore, Maruland 21213												
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Due to (or as e consec	quence of):										
b												
Due to (or es a consec	quence of):										
C												
Due to (or es a conseq	juence of):										
d				-			_					
contributing to death but not re-	sulting in the u	ndertving cause	niven in Part I	23b Did tot	ARCCO HAR COL	ntribute to the cause of death?						
	outing in the	noonying deado	givon art ont.									
						24b. Ware autopsy findings available prior to						
		·		ponou		completion of cause of death?						
				1 ☐ Yes	AQNo	1 ☐ Yes 2 ☐ No						
			26. Place of De	eth (Check only one)							
Hospitel: 1 Inpatient 2] ER/Outpetier	nt 3 DOA	Other: Nursing I	Home 5 ☐ Resider	nce 6 Othe	er (Specify)						
28a. Dete of Injury (Month, Dev Year)		28c. li		T			-					
n												
286. Piece of Injury - At I	nome, ferm, str	eet, fectory, offi	00			per or Rural Route Number,	1					
niner: On the basis of exemine	owledge, deeth	n occurred at the	tima, data and place y opinion, deeth occu	e, and dua to the car urred at the time, da	use(s) and ma	annar as stated. and due to the cause(s)						
and menner steted.												
7-				29		01/1						
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			1/2/1/01	Pd Time	מיניה	MA 21093						
	-	l.	Taring !		· · · · · · · · · · · · · · · · · · ·	110 22000						
	DEMENTIA Due to (b. Due to (c. Due to (d. Due to (d. Due of Injury (Month, Dey Year) 28e. Place of Injury - At 1 building, atc. (Special special	DEMENTIA Due to (or as a consect of the death of the dea	22. Name end Ad Schimune. 3331 Bhe projections that caused the deeth. Do not enter the mode of cone ceuse on each line. e	22. Name end Address of Facility Schimunek Funeral 331 Brehms Lane F plicetions that caused the deeth. Do not enter the mode of dying, such as cardia one cause on each line. e	22. Name and Address of Facility Schimunck Funeral Home, Inc. 3331 Brehms Lane Raltimore. plications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errace one course on each line. e. DEMENTIA Due to (or as a consequence of): b. Due to (or as a consequence of): d. Due to (or es a consequence of): 28b. Place of Deeth (Check only one of the consequence of): 28c. Place of Deeth (Check only one of the consequence of): 28c. Place of Deeth (Check only one of the consequence of): 28d. Deet of Injury All home, ferm, street, fectory, office 28d. Deet of Injury All home, ferm, street, fectory, office 28d. Deet of Injury All home, ferm, street, fectory, office 28d. Location (Sin Chy or Town, one of the consequence of): 28d. Deet of Injury All home, ferm, street, fectory, office 28d. Deet of Injury All home, ferm, street, fectory, office 28d. Deet of Injury All home, ferm, street, fectory, office 28d. Deet of Injury All home, ferm, street, fectory, office 28d. Location (Sin Chy or Town, one of the consequence of): 28d. Location (Sin Chy or Town, one of the consequence of): 28d. Location (Sin Chy or Town, one of the consequence of)	22. Name end Address of Facility Schimunek Funeral Home, Inc. 3.3.31 Bhrehms Lave Baltimore, Manyk one ceuse on each line. e	22. Name end Address of Facility Schumunek Funerhal Home, Tinc. 3331 Brehma Lane Baltimohe, Maryland 21213 Approximate one cause on each line. a. DEMENTIA Due to (or as a consequence of): b. Due to (or as a consequence of): d. Du					

DHMH 16 Ray 6/95



Piease Type or Print in Biack Indeiibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04663 Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month 6:38 A.M. Minnie Mae Bowerman February 2000 4a Facility Nama (if not institution, giva street and number) 4b, City, Town, or Location of Death 4c. County of Death Rosadale Franklin Square Hospital Center Baltimore 8. Data of Birth (Month, Day, Year) 1912 If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Aga (In vrs. last birthday) 9. Birthplaca (State or Foreign Days Months 1□M 2☑F Hours 218-68-1343 87 Maryland Usual Rasidance of Decedant 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No White Marsh Maryland Baltimore 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 11002 Bowerman Road 21162 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 □ Yas 2 □ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status 1 Navar Married 2 Married 1 Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th Grade Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Albert Vernon Trout Amanda Jane Smith 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. Jane Byrd (daughter) 11002 Bowerman Road, White Marsh, MD 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Buriai 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) 2/17/00 Baltimore, Maryland Green Mount Crematory 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Deeth a End Stage Chronic Obstructive Pulmonary Disease Immediate Cause (Finel disease or condition resulting in death) 20 Years Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a consequence of: Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Encephalopathy 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was an autopsy Acute Renal Failure 1 Yas 1 ☐ Yas 2 ☐ No 25. Was case reterred to medical axaminar? 26. Place of Deeth (Check only one) Hospitai: 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar ot Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 2 Accident 5 Pending Invastigation 1 Yes 2 No 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

The law requires that the death certificate be axecuted Box 68760. P.O. Division of Vital Records. or Attending Physician: To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Al

Physician

/Medical

Examiner

Funeral

Director

r 23a-f show notified at

ne 23e or

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OWERMAN, Minnie

Baltimore, Maryland

Pages 1 and 2 should be nent of Health and Mental

Item 27

Physician

/Medical

Examiner

Completed by Physician/Medical

edical Certification: To Be

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Director

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DHMH 16 Rev 6/95

State Registrar

31. Data filed (Month, Day, Year)

29b. Signature and little of certifig

4 Homicide

(Check only one)

29a. Cartifier

30. Nems and addrass of person who completed causa of death (Item 23a) (Type, Print)

Dr. Ritci Mathur, 9000 Franklin Square Drive, Bath

31. Data filled (Month, Day, Van) 32. Registrar's Signeture

Baltimore, Mary land

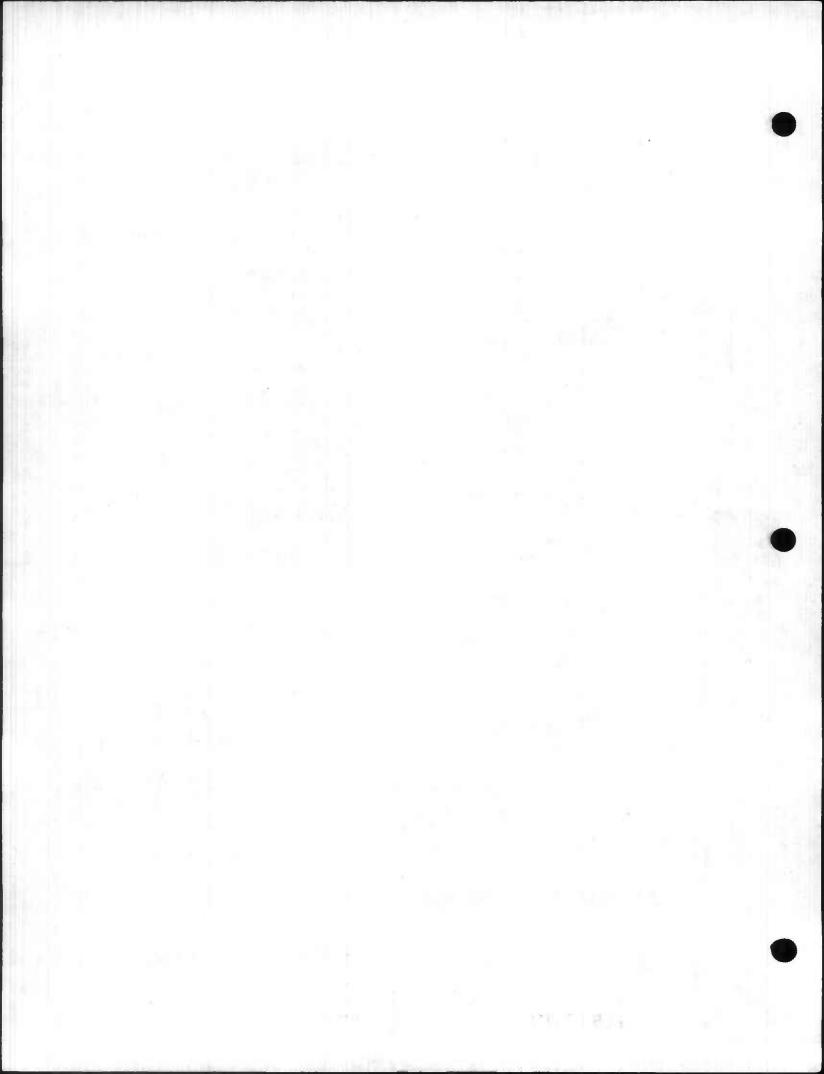
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RD 191825

29d. Data signed (Month, Day, Year)

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Gordon J. Beere 02 12-2000 11:30 PM /Medical 4a Facility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 719 Maiden Choice Lane Apt. # HRT05 Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 MM 2□ F 215-46-6412 90 **Director** 05 13 Md Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits r flams 23a or 28a-f ahow iner must be notified at Md 1 Yas 2 No Baltimore Catonsville 10e, Street and Number 10f. Zio Code 10g. Citizen of What Country? Dir filed within 72 hours efter deeth with 719 Maiden Choice Lane #HRT05 21228 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Yes 22 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 Married 21215-0020 r than "natural", or 1 Yes 2 No Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12 City Police .. Pages 1 and 2 should be filed w timent of Health and Mental Hygie tant: If Nem 27 Is marked other it jury or other traumatic event, in Sergeant altimore. Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Martin L. Beere Mary Weber 19e, Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Beere/wife 719 Maiden Choice Lane #HRT05 Balto, Md21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location · City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any Injury or price. 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park 02 15 Baltimore, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmonds on Avenue, Balto, Md 21228
List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in death) 6 WOOKS brokstive Examiner Due to (or as a consequence of): Examiner aprile the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pug Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 80 for use signed by the a Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 No 1 Yas 2 No certificate 1 Yes or Attending Physician: 25. Was case referred to medicat examiner? edicai Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) a after death.

I Director: After this od in by the funeral di this 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Neturet 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 281. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner as stated.

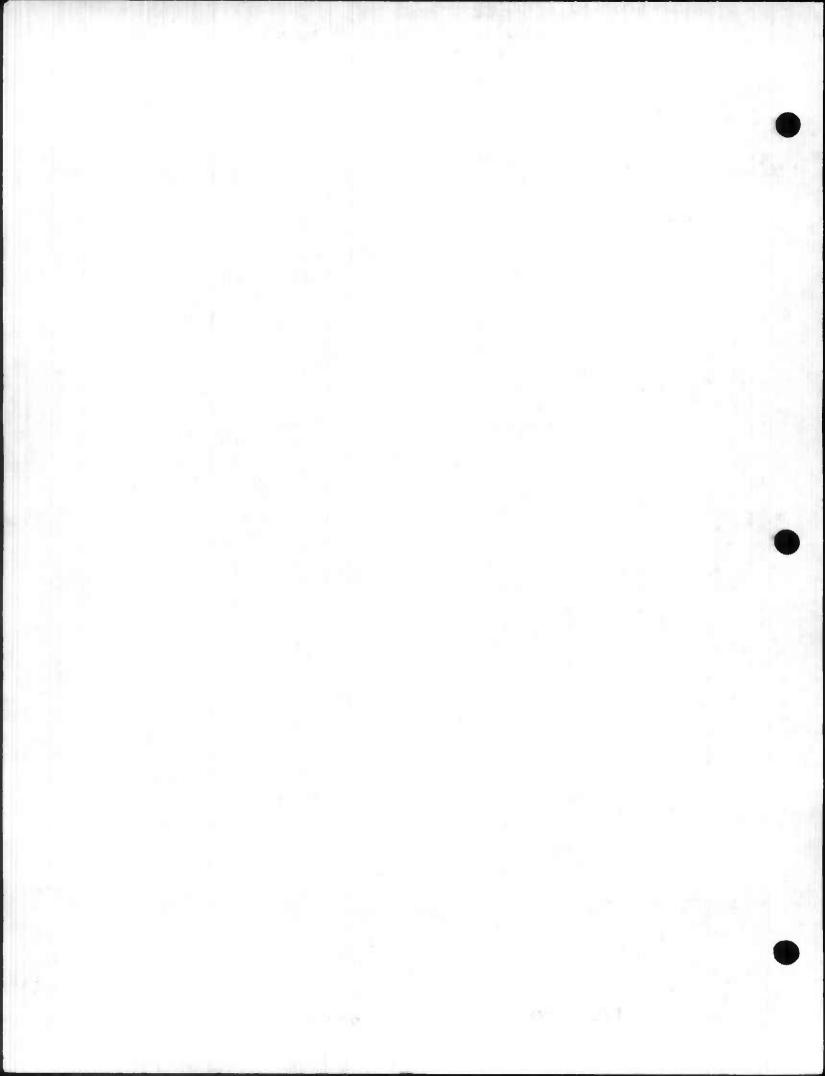
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certified 30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) choice Catorbuille Moiden lane 31. Data filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 5 2000 Registrar

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 4 6 6 5

			Certificate d	of Death	Re	g. No.	04003
sician	Decedent'a Name (First, Middle, Last)				2. Date of Death Month	Day Y	3. Tima of Death
ledical	Cordelia Jane Bealmear				February	14, 2000	9:30 AM
aminer	4e Facility Nema (If not institution, give stree 907 East Wind Road			4b. City, Town, or L Ruxton			imore Co.
eral tor	5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last	t birthdey) If Under 1 Ye Months Da		8. Date of Birth (Month, Day, February	^{Year)} 02,1914 Sy	B. Birthplace (State or Foreig Country) Macuse, New York
	Usual Residence of Decedent 10a. State 10b. County	10c. City. T	Town or Location				10d. Insida City Limite
eted by Funeral Director	Maryland Baltimore Co						1 ☐ Yes 2 🛣 No
Director	10a. Street and Number	J. Ruxu	10f. Zip Coo	le .	10	og. Citizen of Wh	at Country?
ā	907 East Wind Road			04-6705			ces of America
6		Wes Decedent Ever in U.S.					American Indian,
by Funeral	1 Never Married 2 Merried	Armed Forces? I ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify 0	of Hispanic Origin? (Sp Cuban, Mexicen, Puerto No Specify:	Rican, etc.)	Black, Specify:	White, etc. White
Completed	15. Decedent's Education	on 1	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	cupation	king	16b. Kind of Buai	ness/Industry
pie	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use re	ine during most of wor tired)	king		
To Be Compi	12	04	Home !	Maker		Own H	tome
Be	17. Father'a Name (First, Middle, Last)			18. Mother's Nem	e (First, Middle, N	feiden Sumame)	
To	Albert Murdock Doty			Cordelia V	iolet Scot	t	
	19a. Informant's Name/Relationship (Type, I	Print)	19b. Meiling Address (Str	eet and Number or Au	ral Route Number,	City or Town, St	tate, Zip Code)
	Mr. James Irving Bealmear,	Jr.(Husband)	907 East Wind	Road Ruxton,	Maryland	21204-670	05
	20a. Method of Disposition	20b. Plac	se of Disposition (Neme o		-	20c. Location - C	ity or Town, Stala
	1 2 Burial 2 ☐ Cremetion 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		n Park Cemeter		2/16/2000	Baltimore	e, Maryland
9300		Deffrey L. Gair		1			ne, Inc. Md. 21204-2515
	23a Part Fold the three of complicate	ns that caused the death					
	23a. Party Enfer the discome, of complicate shoot, or near layure. List only one ca	auae on each line.	DO NOT GINES THE SHOOL OF	dynig, soon as carolac	or respiratory arre	701,	Approximete Interval Between Onset and Death
n al	Immediate Cause (Final	Immediate Cause /Final					
er	disease or condition resulting in death)	Meumonia					12 days
l in		Due to (or a	s a consequence of):				
틸	b						
Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or es	s e consequence of):				i i
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
edicai	that initiated events resulting in death) Last	Due to (or as	s a consequence of):				
Me	d						
Ta .							
Physician/M	Part ff. Other significant conditions contribu	uting to death but not resulting	ng in the underlying cause	given in Part I.	23b. Did to	bacco uae conti	ribute to the cause of death
P	Alzhimer's	Dementer			1□ Ye	s 20 No 3	Probably 4 Unknow
by							
Completed by Physician/N					24a. Was ai		24b. Were autopsy findings available prior to
pje							completion of cause of death?
Out					1 □ Ye	s 20 No	1 Yes 2 No
Be	25. Was case referred to medical			26. Piace of Dea	th (Check only on-	e)	
To E	exeminer?	itel:	VOutpatient 3□ DOA	Other: 4 Nursing H	ome # Reside	nce 6 Other	(Specify)
n: To Be Comp	27. Manner of Death	8a. Date of Injury (Month, Day Year)	8b. Time of 28c.	njury at Work?	28d. Describe ho	w injury occurred	d
tio	1 □ Netural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)		1 Yes 2 No			
flee	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify)				28f. Location (St. City or Town		or Rurel Route Number,
ert				e time, date and place	and due to the ce	euse(s) and meni	ner as stated.
dical Certification:	(Check only 2 Medical Examiner:	n: To the beat of my knowle On the basis of examinetion and manner stated.	edge, death occurred at the nand/or investigation, in r	ny opinion, deeth occu	rred at the time, de	ate and place, an	d due to the cause(s)
Medical Certi	(Check only 2 Medical Examiner:	On the basis of examinetion	and/or investigation, in r	ny opinion, deeth occu	rred at the time, de	ate and place, an	(Month, Day, Year)
edicai	(Check only one) 2 Medical Examiner:	On the basis of examinetion	and/or investigation, in r	ny opinion, deeth occu	rred at the time, de	9d. Dete signed	(Month, Day, Year)
Medical Certi	(Check only 2 Medical Examiner: one) 29b. Signature and title of certifier (Colors 7)	On the basis of examinetion and manner stated.	n and/or investigation, in n	ny opinion, deeth occu	rred at the time, de	ate and place, an	(Month, Day, Year)
edicai	(Check only one) 2 Medical Examiner:	On the basis of examinetion and manner stated.	n and/or investigation, in n	ny opinion, deeth occu	rred at the time, de	ate and place, and glace and glace and place, and glace	(Month, Day, Year)

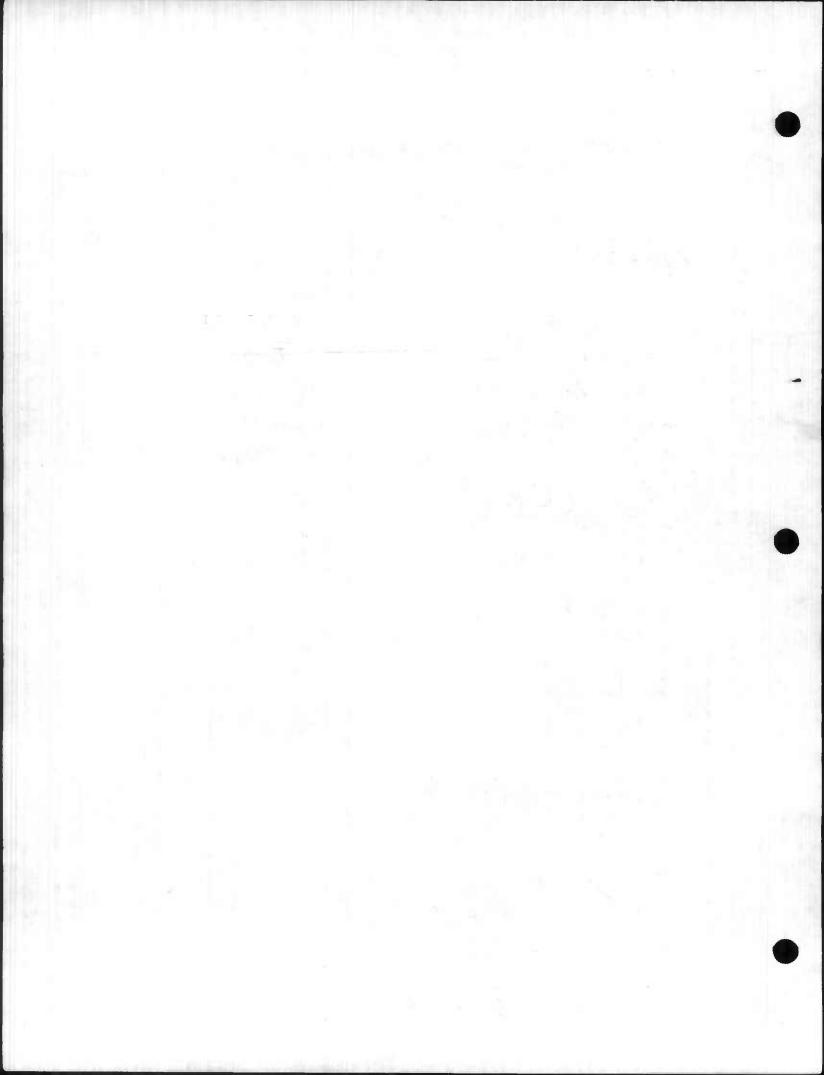
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State of Maryland / Department of Health and Mental Hygiene O O O L C

AMENDED ITEM #16a	PER FH G780 2/15/2000 AH	Certificate		Reg. No.				
Physician	1. Decedent's Nama (First, Middla, Last)	arksdale	2. Date of Month					
/Medical Examiner	4a Facility Name (If not Institution, give street and num	iber] ON - Univers	ity 4b. City, Town, or Location of D					
Funeral Director	5. Social Security Number 6. Sex 1 M 2047	. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs. 8. Date of Deys Hours Min. (Month,	Birth Day, Year) 3 1 - 1934 9. Birthplace (State or Foreign Country)				
2 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits				
the Maryli 28s-f sho notified at	mp. N/A	BALTO.		1 Des 2 □ No				
5 6 0	100. Street and Number 1712 E 28 57	101. Zip 0		10g. Citizen of What Country? US A				
020 ors after death v is, or items 23 Exemple: must by Funeral	1 Never Married 2 Married 1 Yes	2 No 1 Yes 2	ent of Hispanic Origin? (Specify Yas or fy Cuban, Mexican, Puerto Rican, etc.) No Specify:	No- 14. Race - American Indian, Black, White, atc. Specify: BLACK				
1 21215-0020 and within 72 hours at Volence. The Medical Exam. Completed by 8		16a. Decedent's Usual (Give kind of work life. DO NOT use	done during most of working pretired)	ECHNICI AND. Kind of Business/Industry				
ind 2.	17. Father's Name (First, Middle, Last)	CAN-UID-	18. Mother's Name (First, Mid	HOSPITA -				
Maryland 62 should be lile 7 is marked othe braumatic event. To Be C	WILLE BARKS d.		LUFANNI					
Mar d 2 sho d 2 sho dh and T is m trsum	19a. Informant's Neme/Reletionship (Type, Print) SANDRA HORTON	19b. Meiling Address	(Street and Number or Rural Route Nu					
Baitimore, Namil: Pages 1 and	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from S 4 Donation 5 Other (Specify)	7	e of her place) CHURCH 2/10/10	20c. Location - City or Town, State				
Balti permit. Departm importa eny inju	21. Sonature of Funaral Sarvice Licenses 22. Nama and Address of Facility BETTS FUNERAL HOME BALTO MD 1129 N. CAROLINE 8+ 21213							
No.	23a. Further the disease, or complications that can book, or heert failure. List only one ceuse on ea							
Physician /Medical Examiner	Immediate Cause (Final disaase or condition resulting in death) a.	Cut Myocaro	ha Infare	tion MIN				
D = D		Due to (or es a consequence of)	Part Tailier	e				
), executed in and tel-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	ata A	- pan O				
6876(filcate be physicia as the bur	Cause (Disease or Injury that initiated events resulting in death) Last	Jewse						
Box (leath certif			ves rives in Post I	Did tobacco use contribute to the cause of death?				
cords, P.O. Box requires that the death certi been signed by the attending should be detached for use a	Part II. Other algnificant conditions contributing to del	TOUR TO Tresulting in the underlying ca		1 Yes 2 1 165 3 Probably 4 Unknown				
Cord requir been s should	Sypoth	moidism	24a. V	Vas an autopsy enformed? 24b. Ware autopsy findings available prior to completion of cause of death?				
f Vital Recypican: The low yalcian: The low director, page 2	25. Was case referred to medical	Lupus En	1, 100,000	□Yes 212No 1□Yes 215No				
of Vita hysicians his certifical director	examiner? Hospital:	patient 2 ER/Outpatient 3 DO	26 Place of Death (Check or A Other: 4 Nursing Home 5 F	Residence 6 Other (Specify)				
Division of Vita To the Hospital or Attanding Physician: The Functs after death. To the Functs Director: After this certific completely filled in by the functal director. Medical Certification: To Be (2 Accident investigation	f Injury h, Dey Year) 28b. Time of Injury M	Work? 1 □ Yes 2 □ No	ibe how injury occurred				
Division C To the Hospital or Atlanding P within 42 hours after death. Completely filled in by the Unsafer completely filled in by the Unsafer Medical Certification:	3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At home, ferm, street, factory, g, etc. (Specify)	office 28t. Locatio	on (Street and Number or Rural Route Number, Town, State)				
Ne Hospi n 24 hound ne Funer bletely fill edical				the cause(s) and manner as stated. me, date and place, and due to the cause(s)				
with to the common of the with	29b. Signature and title of confider Man	14 of 1	License number	29d. Date signed (Month, Day, Year)				
04-4	30. Name and address of person who completed cause	of death (Item 23a) (Type, Print) MARRA	MDI					
State Registrar	31, Date filed (Month Day, Year) 2000	egistrar's Signature	uks)					



Please Type or Print in Biack Indelibie ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. 8, Lillian Braun 2000 1:58 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 411 Whitaker Mill Road Fallston Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Hours Months 1 M 2 KF Yrs. 92 213-60-0520 July 31, 1907 Baltimore, Maryland **Usual Residence of Decedent** 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 411 Whitaker Mill 21047 Road U.S.A 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 yrs. n/a Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Koenig Mary Kummer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Betty J.Glock (Daughter 411 Whitaker Mill Road Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cemetery2/11/2000| Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licelly E.F.Lassahn Funeral Home 6. 11750 Belair Road Kingsville, Maryland 21087 ac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ischemic Cardiomyohath Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HORTIC STENOSIS 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 TYes 2 No

Physician /Medical Examiner

Department of Important: If any injury or other

Physician

/Medical

Examiner

10s. State

Funeral

Director

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Pages 1 and 2 should be flied within 72 hours after d next of Health and Mental Hygiene. with if term 27 is merked other than "natural", or flee ury or other traumatic event, the Medical Examinate

altimore, Maryland 21215-0020

Box 68760,

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Division of Vital Records,

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Examiner Physician/Medical P Completed Be Certification: To n 24 hours after deeth.

Ne Funeral Director: After plets of the fur.

edical 29a. Certifier completely (Check only within 2 29b. Signature and title of certifier

2 Accident

3 Suicide

4 Homicide

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D-16444 29d. Date signed (Month, Day, Year) Le Cruany 8th 2 8th 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Altending 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIJAY. S. NAIRM.D. 2112 BELAIRROAD: FALLSTON: MD21047. 31. Date filed (Month, Day, Year)

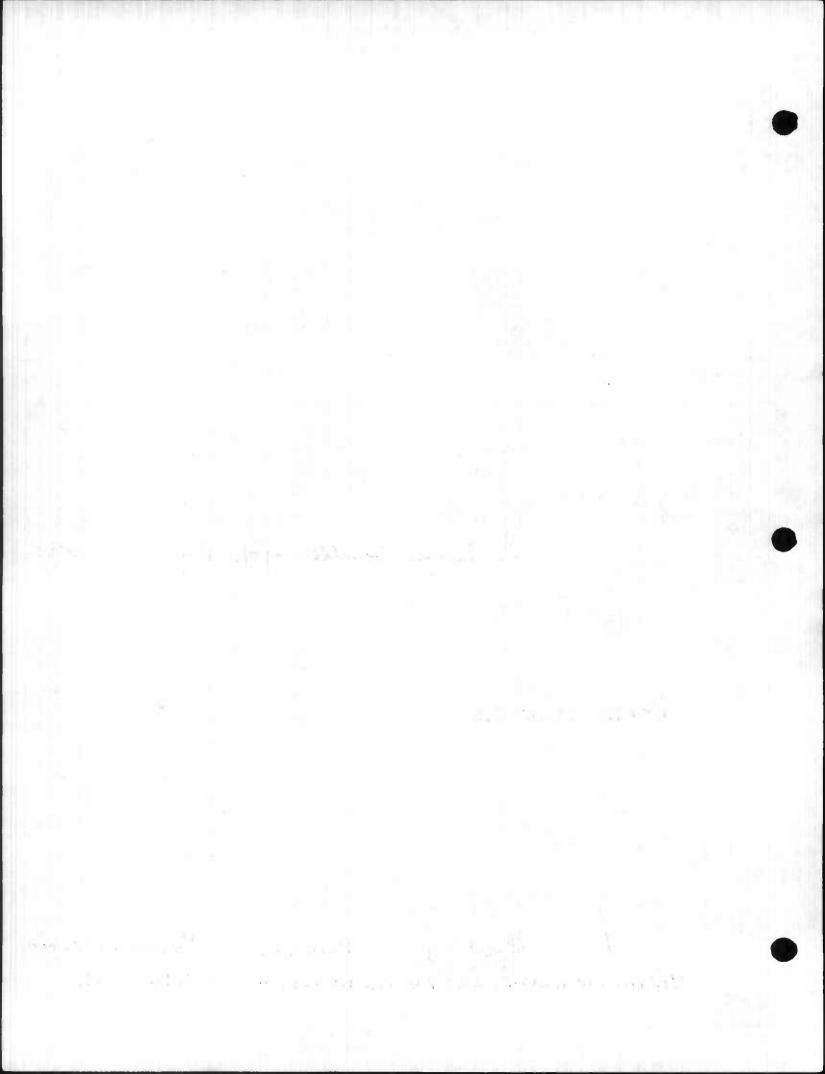
State Registrar

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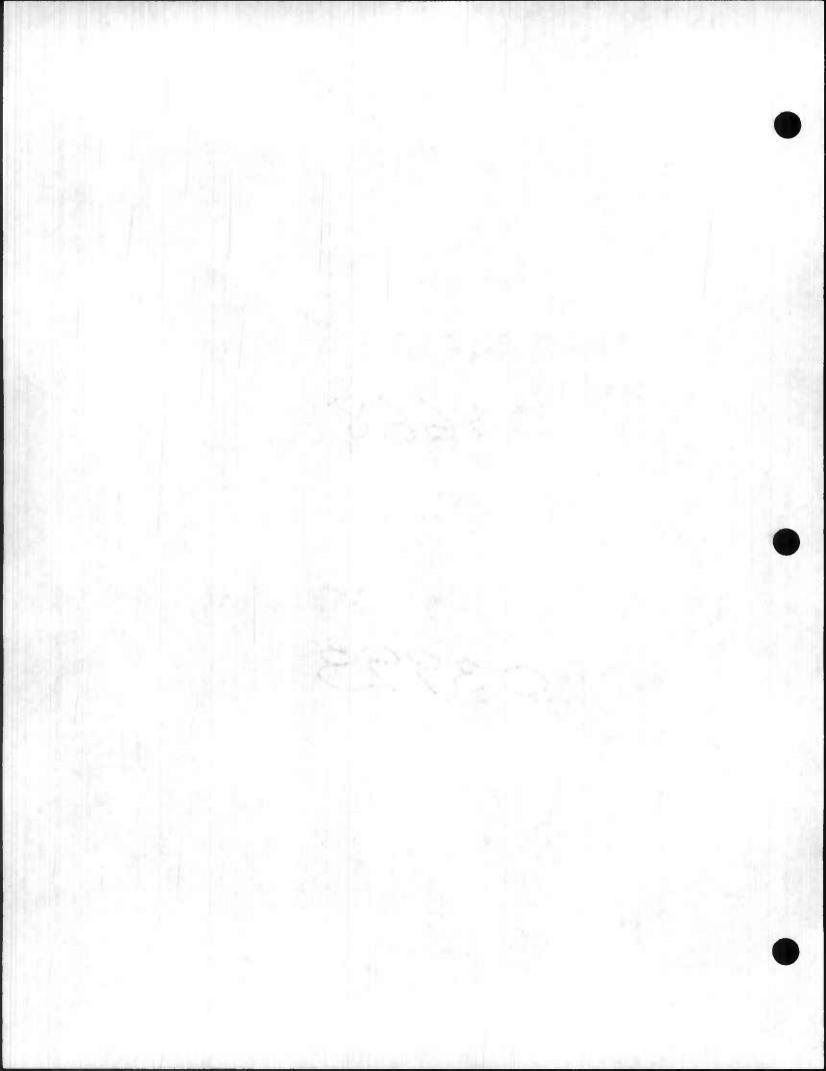
6 ☐ Could not be



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#1 perPHY,#17 perFHG78B 3/1/2000 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year February MARY A. BATTEY Mary H. Bailey 07:09 14 2000 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ST. AGNES HOSPITAL Baltimore If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) Days 1□M 2QF Months 63 216-32-4169 VA. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits No Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1607 WARWICK AVE. 21216 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give △ Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 17. Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) JAMES R. CONNLEY Conley NOVELLA BLACKWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) EDWARD BAILEY (HUSBAND) 1607 WARWICK AVE. BALTIMORE, MARYLAND 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBuriat 2 Cremetion 3 Removal from State ARBUTUS MEMORIAL PARK 2-18-2000 BALTIMORE, MARYLAND 5 Other (Specify) 4 Donation 22. Name and Address of Facility VERNON R. BAILEY FUNERAL SERVICE of Funeral Senson Licen 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Penti. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximeta Intervel Between Onset end Deeth Immediate Cause (Finet disease or condition resulting in death) monary ne Week Bupass One Month Durger Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Known that initiated events resulting in death) Last Due to (or as a consequence of) Unknown iabetes 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 WUnknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1⊠Inpatient 2□ER/Outpatient 3□ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 T Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Physician /Medical Examiner

Physician

/Medical

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Funeral

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Hygiene.

Pages 1 and 2 should be lied than of Health and Mental Hygient: if Item 27 is marked other?

Department of Health at Important: If Nem 27 is any injury or other trau

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altimore, Maryland 21215-0020

Box 68760.

P.O.

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Division of Vitai Bailey

must be notified at

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Examiner Physician/Medical þ Completed Be Certification: To

The law requires that the death certificate be executed physician and s the burial-trans signed by t s certificata has t director, page 2 s Attending Physician: director. death. Director: after A 24 hours a Funeral I To the Hosp within 24 hor To the Fune completely fi

0) State Registrar

DHMH 16 Rev 6/95

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)

29a. Certifier

address of person who completed cause of death (Item 23a) (Type, Print)

Consor

32. Registrar's Signature

900

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

enue

29d. Data signed (Month, Day, Year)

Daltimore

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Physician Expene Clark January 26, 2000 12:35 am /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park, MD Montgamery If Under 24 Hrs. If Under 1 Year Birthplace (State or Foraign Country) **Funeral** Hours Months

Director

Director

Funeral

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Completed

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r 28a-f show indiffed at ahow å "natural", or Herne 23s or must be

Hygiene. "natural", or has permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked or

altimore, Maryland 21215-0020

Physician /Medical Examine

Examiner physician and the buriel-transit The lew requires that the deeth certificate be executed Box 68760. /sician/Medical for use es 8 Division of Vital Records, P.O. the To the Hospital or Attending Physicien: within 24 hours effer deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director;

State Registrar

5. Social Security Number 131–16–7163 8. Data of Birth (Month, Day, Year) March 17, 1927 7. Age (In yrs. last birthday)
72. Yrs. Days 1₩ 2□ F **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Mantgarery Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rosecroft Drive 20744 USA Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Navy
PCIYes 2 No
If Yes, Give
Year or Datas: Black, White, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Uhknown Veronica Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Cynthia L. Christ / Daughter 2971 Groth Road, Holley NY 14470 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from Stata Rochester Crematory January 31, 2000 Perintan, NY 4 ☐ Donation 5 ☐ Other (Specify) e of Euperal Service Licensee Victor P. Doda, Jr. 22. Nama and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Daath Immediate Cause (Final disease or condition resulting in death) MAG Due to (or as a consequence of) DENALINC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): HROMIC HEAN Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

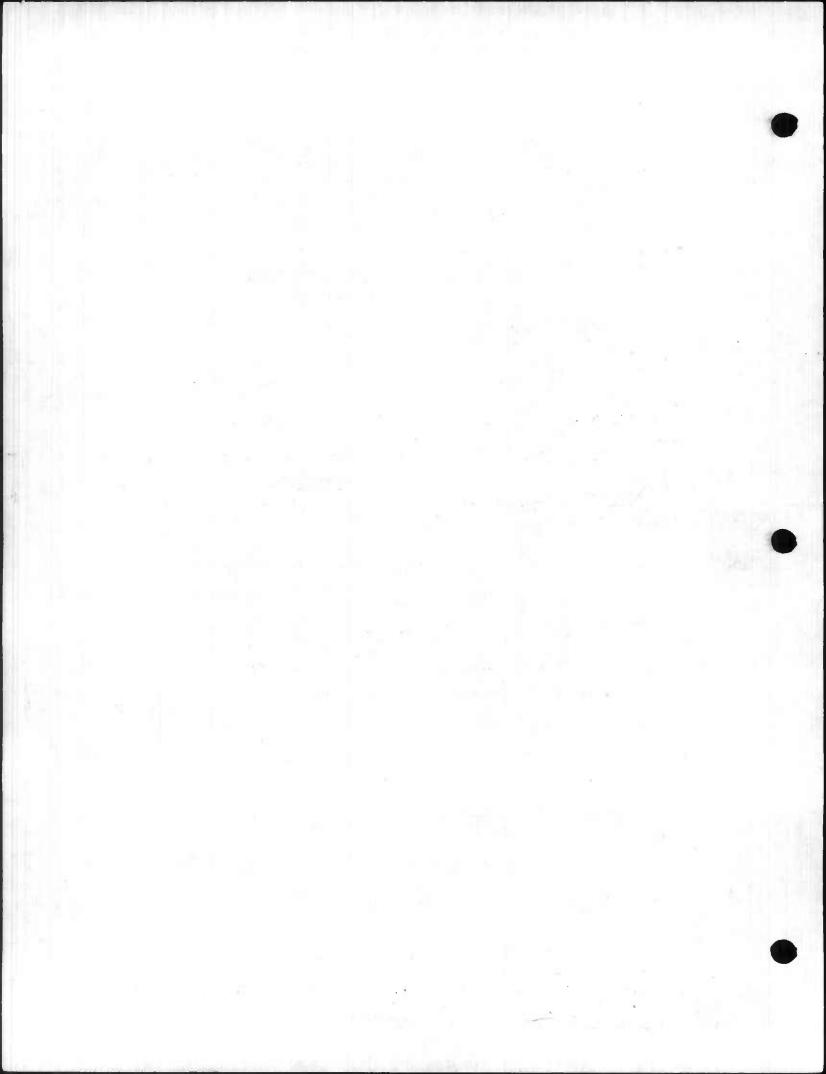
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To Be	25. Was case referred to medicat axamiper? 110 res 2 No AGC//	fospital: 1 7 Inpatient 2	ner (Specify)				
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury M	28c. tnjury at Work?	28d. Describe how injury occur	пеd	
Certifica	3 Suicide 6 Could not be 4 Homicide detarmined	28e. Place of Injury - At h building, etc. (Speci		ory, office	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)		
dical					e, and due to the cause(s) and m urred at the time, data and place,		

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1 ☐ Yas 20XNo

29b. Signature and title of certified 29c. License number MD OCH cause of death (Item 23a) (Type, Print) 30. No

31. Date filed (Month, Day, Year) 32. Registrar's Signatura

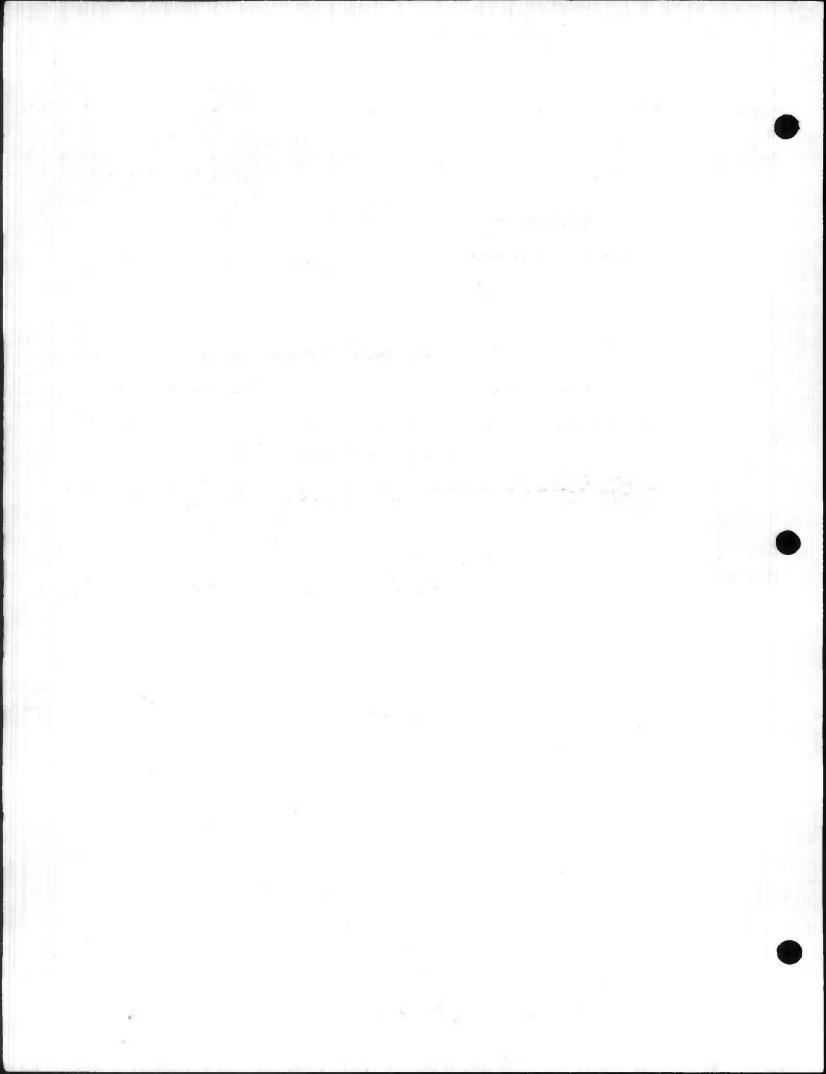


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State of Maryland / Department of Health and I	Mental Hygiene	0467
Certificate of Death	00	0701

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П	Physic	lan	Decedent's Name (First, Middle, I					2. Date of Death Month		3. Time of Death																
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	Funeral Director		070 03 3073	Sex 7. Ag 1 M 2 F	a (In yrs. last birt 97	hday) If Under 1 Yea Months Days		8. Data of Birth (Month, Dey, 1) Sept. 13	Year) 9. Birthy Coul. 1902 Hill	place (State or Foreign ntry) side, NJ																
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	th with the	ai Dire	10e. Street and Number 13801 York Road	Unit T-30	2	10f. Zip Code	21030	10	g. Citizen of What Cour USA	ntry?																
020	72 hours after deeth with the Maryland natural, or Itema 23a or 28a-f show areal Examiner must be notified at	by Funeral Director	11. Maritai Status 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Armed Forcas? 1 Yes 2 If Yes, Give Year or Detes:		13. Was Decedent of if Yes, specify Cui		pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	atc.																
21215-0020	A 36	leted	15. Decedent's (Specify only highest g	Education rade completed)	16e.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	during most of wor	king	6b. Kind of Business/In	dustry																
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Maryland	th and traum		19a. informent's Name/Relationship			Mailing Address (Stree																				
	permit. Pages 1 end 2 s Department of Health ar Important: If Item 27 is any Injury or other trau pnce.		Richard F. Con 20e. Method of Disposition 1 Burial 2 Acremation 3	-	20b. Place of cemeter	Seminary Disposition (Name of y, cremetory or other plants)	ace) T		7111e, MD 2 Oc. Location - City or To																	
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k 68760,	lew requires that the death certificete be executed as been signed by the ettending physician and a 2 should be deteched for use as the buriel-transit	VMedical Examiner	√Medical Examine	n/Medical Examine	n/Medical Examin	n/Medical Examin	n/Medical Examin	n/Medical Examin	n/Medical Examin	n/Medical Examin	Physician/Medical Examin	n/Medical Examin	n/Medical Examin	n/Medical Examin	n/Medical Examin	n/Medical Examin	n/Medical Examin	n/Medical Examin	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last	с.	Due to (or as a c		c obstru	othe pul	monory discoses	20 yr
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of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	2	2	2	5	5	5	5	5	5	1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending 2 Accident investigati	Hospital: 1 Inpatie	y. 28b. T	ime of 28c. Injury		ome 5 Residen 28d. Describe how	nce 6 Other (Special vinjury occurred	(y)								
Division	of or Atta	Certification:	3 Suicide 6 Could not determine	28e. Place of Inju- building, etc	iry - At home, fer (Specify)	m, street, factory, office	,	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,																
	To the Hospital or A within 24 hours after To the Funeral Direction plately filled in b	edical C	29a. Certifier (Check only one) 1 ☑ Certifying F 2 ☐ Medical Exe	hysician: To the best o miner: On the basis of and manner sta	examination and	deeth occurred at the t Vor investigation, in my	ime, date and place opinion, death occur	, and due to the cau rred at the time, dat	use(s) end mannar as a le and piace, and due to	tated. o the cause(s)																
	o the	Mec	29b. Signetyre and titla of certifier	and manner Sta		29c. Lican	sa number	290	d. Date signed (Month,	Day, Year)																
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	(V		30. Name and address of person who	carreleted cause of de	eeth (Item 23a)	Type, Print) 1. /38	101 YO	Rt RI	D., COCKE	EVSVILLE																
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Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month **Physician** 9:15 A.M. February /Medical 4e Facility Nema (If not institution, giva street end number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital osedale Franklin Square Baltimore If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F -46-5050 Director Usual Rasidance of Decedent Pages 1 and 2 ahould be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
snt: If Item 27 is marked other than "natural", or Items 23e or 28e-f ahow 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** 7 is marked other than "natural", or flams 23a or 28a-f treumstic event, the Madical Examinar must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 502 12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No White Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) lam 19a Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Tip Code) or other tr 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other) 20c. Location - City 1 Burlal 2 Cremetion 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Part1. Inter the disease, or complications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failura. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel . Sepsis 24 Hours disaasa or condition resulting in death) Examiner Due to (or as e consequence of): edical Certification: To Be Completed by Physician/Medical Examiner Endocarditis The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thei initieted events rasulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) ate has been signed by the attending p page 2 should be detached for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Hepatic Failure, Renal Failure, Peripheral Vascular Disacse, 1 Yas 2 No Diabetes Mellitus Type II, Congestive Heart Failure 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? Arteriosclarotic Cardiovascular Disagse 20 No 1 ☐ Yes 2 No 25. Was case referred to medical examinar? or Attending Physicien: funeral director, 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No After this 27. Manner of Deeth
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. fnjury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A the f 6 Could not be 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the

State Registrar

29b. Signature and fillin of certifie

31. Date filed (Month, Day, Year)

FEB 1

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Or. Tik Kg L. Ng, 9000 Franklin Square Drive.

2000 5

32. Registrar's Signetura

DHMH 16 Rev 6/95

29c. License number

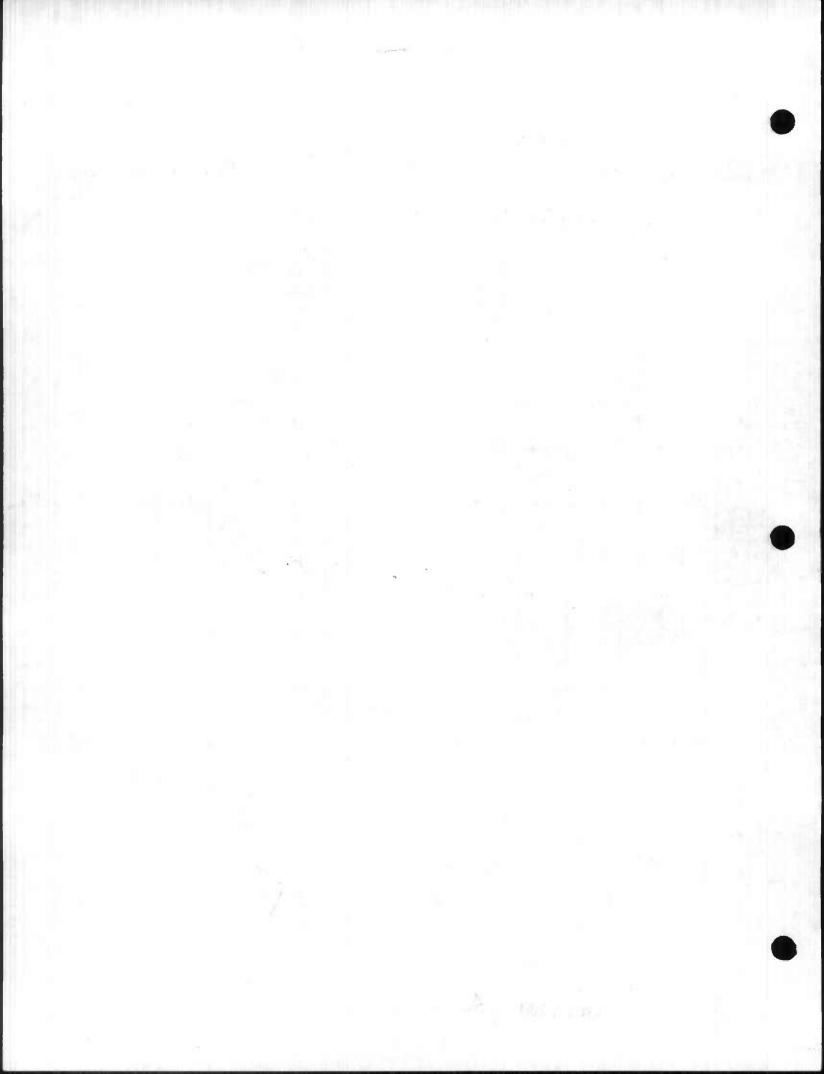
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Baltimore, Maryland

29d. Date signed (Month, Day, Year)

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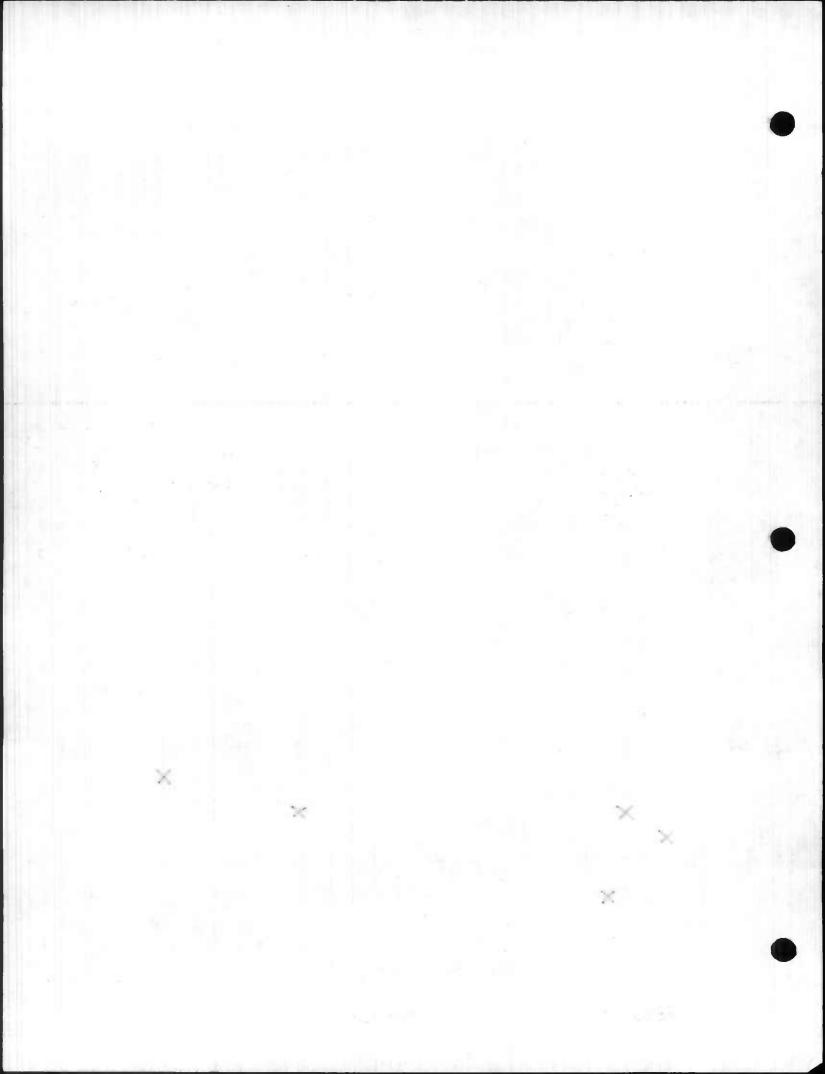


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State of Maryland / Department of Health and Mental Hygiene

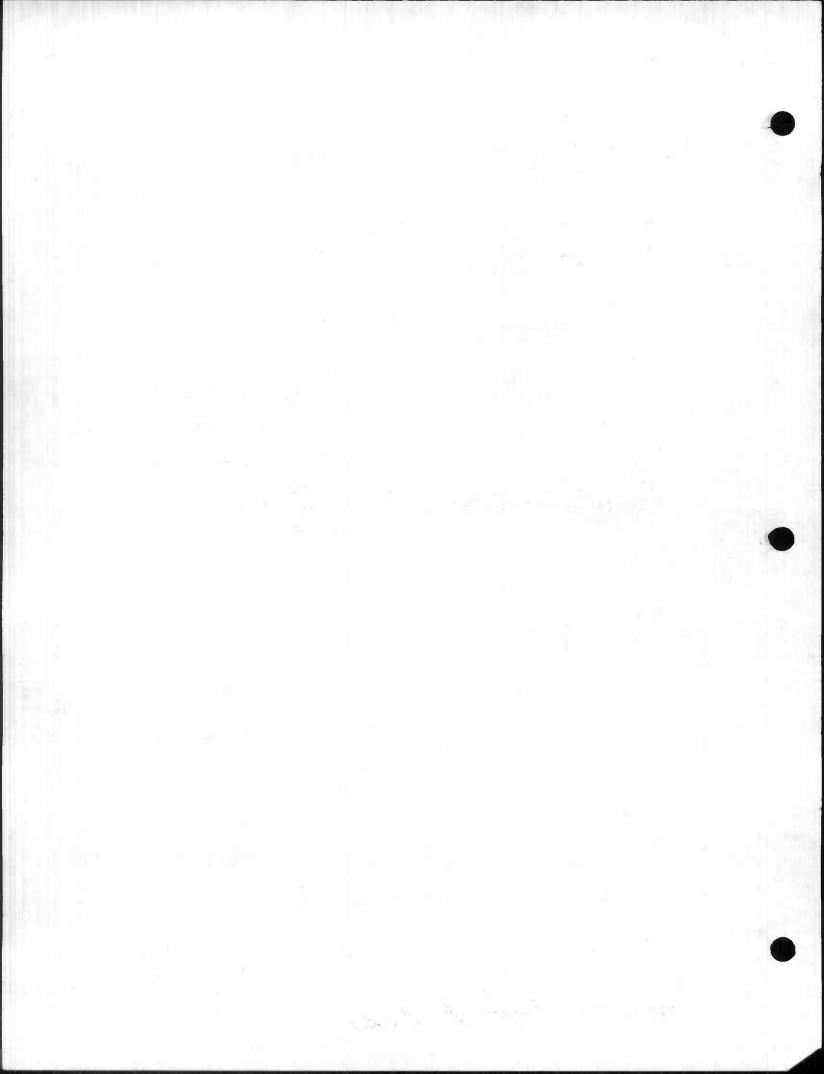
	Certificate of Death		eg. No.	146/3	
Dhuaisian	Decedent's Name (First, Middle, Last)	2. Deta of Deat Month	h Dev Yeer	3. Time of Death	
Physician /Medical	Frances Helen Carter	Februar			
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or		4c. County of Dea	ath	
	Catonsville Commons Catons			timore	
Funeral Director	5. Scclal Security Number 210-16-7072 6. Sax 1 M 24 F 7. Aga (In yrs. last birthday) Months A F 94 Yrs. 6. Sax Months Days Hours Min.			irthplece (Stete or Foreign Country) aine	
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death with the Maryla erre 23e or 25e-f show ir must be notified at meral Director	300 Bloomingdale Avenue 21228		USA		
O20 or she ef. or h Examin	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U,S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puer If Yes, Give Yaar or Dates:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:		
I 21215-0 ed within 72 ho ygiene. we then 'netur it, the Medical.	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rkina	16b. Kind of Busines	s/Industry	
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C 2 24 F	Priscilla L. Flynn/daughter 60 Glenwood Ave.,	Catons	sville,	MD 21228	
altimore, mit. Pages 1 a partment of His portant. If hem y Injury or othe	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) St. John's Cemetery 0		20c. Location - City o Ellicott		
Balti permit. Departm imports eny inju	21. Signature of Europa Service Licensee 22. Name and Address of Facility MacNabb Funera				
	Edward A. Gregorchik 301 Frederick 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			MD 21228 Approximata Interval Between	
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. ATHEM 0 SCLENOTIC CAND/0 Companies to the consequence of	MENEN	n Dis	Onset and Death	
K 68760, antificate be executed ing physician and e as the burial-transit Medical Examiner	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):				
P.O. Box at the death certification of the attending elected for use a Physician/M	0.				
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() - 110 -	DEMEMTIA	24a. Wes a perform		. Were autopsy findings available prior to completion of cause of death?	
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tanding Physically. to: After this of the funeral dis	27. Manger of Death 1 Netural 5 Pending 28a. Date of Injury 28b. Tima of Injury 28c. Injury at Work? 28c. Injury at Work?	1	ow injury occurred	веспу)	
Division of the control of the contr	2 Accident Investigation 3 Suicide 6 Could not be detarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)	281. Location (St City or Town	reet and Number or I n, Stete)	Rural Route Number,	
Hospi 4 hours Funer tely fill	29a. Certifiar (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place (Check only one) Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place (Check only one)				
To the He within 24 To the Fu complete	29b. Signeture and title 4. annual 29c. License number	2	9d. Dete signed (Mor	nth, Day, Year)	
PSF 0	12033	3	2/11/	88	
9	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ENTA F	= n	OUTTO	
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signature	11/10	- /	MD	
Registrar	FEB 1 5 2000 Server B. Sparks				

DHMH 16 Ray 6/95



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G780 2/15/00 yg Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** tehruan /Medical RUNDER Min. B. Date of Birth (Month, Day, Year) 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltmore Maryland 6. Sex Medica enter li Year 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number 45 9. Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Months Days 216-86-064 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXes 2 No Director 28a-f Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 mart by 3918 Woodhaven Ave 21216 U.S.A. death Funeral 12. Was Decedenl Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after men of Health and Mental Hygiene.
If If em 27 is marked other than "natural", or the mry or other traumatte event, the Mental Elemina lary or other traumatte event, the Mental Elemina. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2th grade Laborer Various Jobs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Christina Satchell Willie M. Claud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3918 Woodhaven Ave. Baltimore Md 212 of Disposition (Name of Disposition (Name of Disposition (Name of Disposition City or Town, State Christina Claud-Mother 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of h Important: If he any injury or off 1 Burlei 2 Cremation 3 Removat from State 4 ☐Donation 5 ☐ Other (Specify) King Memorial Park 2/12/2000 Randallstown, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H West 23a. Part1. Enter the disease, or complications their caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 **Physician** /Medical Immediate Cause (Final umonia disease or condition resulting in death) Examiner Due to (or as a consequence of): oration the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical The law requires that the death certificate Due to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Tourknown Lymphotropic Records, Completed by 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 25 No Impatient 2 ER/Outpatient 3 DOA this funeral Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 Panding 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29a. Certifier (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cativa Byrd . M. Date tiled (Month, Day, Year) Baltimore, UD 21201 South Green 32. Registrar's Signature State FEB 1 5 2000 Registrar DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Dey 9 ELIZABETH C. COVINGTON 2000 5 30 p.m. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Pikesville 4709 Parmelee Road If Under 24 Hrs 8. Date of Birth (Month, Dey, Year) 9-28-1947 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (Stete or Foreign Country) Deys Months Hours 10 M 20 F 216-52-1269 52 N.Y. Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside Cltv Limits Md Balto 1 Yes 2 No Pikesville 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 4709 Parmelee Road 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No 1 Never Merried 2 Merried specify: Black 1 Yes 2 No If Yes, Give Yeer or Deles: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondery (0-12) College (1-4or 5+) Claims Adjuster 12th grade year 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Christopher Allen Ethel Burch 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pikesville, Md 4709 Parmelee Road James Covington -Husband 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stele 1 Bugar 2 Cremation 3 Removal from State Garrison Forest Vet 2-17-00 Owings Mills, Md 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 Frier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, on hear feiture. List only one cause on each line. Approximata Interval Between Onset and Deeth disease or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1☐ Yes 25 No Hospital: Other: 4 Nursing Home 5 Handence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Deeth 1 Naturel 2 Accident 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and another stated. 29a. Certifier

hysician and the burial-transit The law requires that the death certificate be executed Box 68760. signed by the a Division of Vital Records, P.O. or Attending Physician: After this 24 hours after death. Funeral Director: A Hospital

Physician

/Medical

Examiner

Director

Funeral

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Funeral

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filed within 72 hours after

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Department of Health ar Important: if Item 27 is any Injury or other trau

Physician

/Medical Examiner

Physician/Medical Examiner

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Medical Certification: To Be Completed

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Baltimore, Maryland 21215-0020

within 2 State Registrar

DHMH 16 Rev 6/95

31. Dale filed (Month, Dey, FEB 1 5 2000

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29b. Signatu

32. Registre s Signeture

n 23a) (Type, Print)

29c. License number

29d. Date signed (Mont)

Day, Year

- June James

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	AN	State of Maryland / Department of Health and MEND #8 & 18 PER F.H. G780 2-15-2000 J.A. Certificate of Death		jiene	04676
		1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	-	3. Time of Death
	Physician /Medical	Physician Anne Marie Calka			0955
	Examiner	4e Facility Name (If not institution, give street and number) 4b. City, Town, or	Location of Death	2 0 0 0 4c. County of D	eath
		Anne Arundel Medical Center Annap			Arundel
	Funeral	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs. Months Days Hours Min Months Min M	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director	131-18-9345 81 Usual Residence of Decedent	12 12	-1918 Cc	nnecticut
	Mand Mand	10a. Stale 10b. County 10c. City, Town or Location			10d. Inside City Limits
	r 28a-f show incurred at	Ct Fairfield Greenwich			1 Yes 2 □ No
	with the Maryland a or 28a-1 show Libe notified at	10e. Street and Number 10f. Zip Code	1	Og. Citizen of What	Country?
	th wit		1000	USA	
	r Rema 23a resemble Teneral	11. Marilal Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 lf Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
20	ar. or h	1 Never Married 2 Merried 1 Yes 2 图 No If Yes, Give 1 Yes 2 图 No Specify: Year or Dates:		Specify:	771- 1 1 -
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Maryland	~ 2 4 3	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship)			
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10	T ha	1 Buriel 2 ☐ Cremation 3 ☐ Removel from State cemetery, crematory or other place)			
altimore,	rtant:	4 Donation 5 Other (Specify) St. Mary Cemetery	02 10	Greenwi	.ch, Ct
Ba	permit. Pages 'Department of I Important: If ha any injury or of godge.	21. Signature of Funeral Service Licensed 22. Name and Address of Facility Sterling-Ashto: 736 Edmondson			
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Records,	requires that een signed b hould be dete		24a. Was a	n autopsy 24	b. Wera autopsy findings
00	- D		perfor	med?	available prior to completion of cause of death?
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Ž	after da after da Directed in by the ertific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		Rural Route Number,
	hours at neval D in filled in the cal Ce				
	五名正常 号	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and plac (Check only one)			
	within 2 To the comple			29d. Date signed (M	onth, Day, Year)
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	2	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		2-7-2	
	/W.	Robert T Peterson my 600 Redicty tre	Annop	dis med	21401
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	0		•
	Registrar	FEB 1 5 2000 Jenne B. Spacks			

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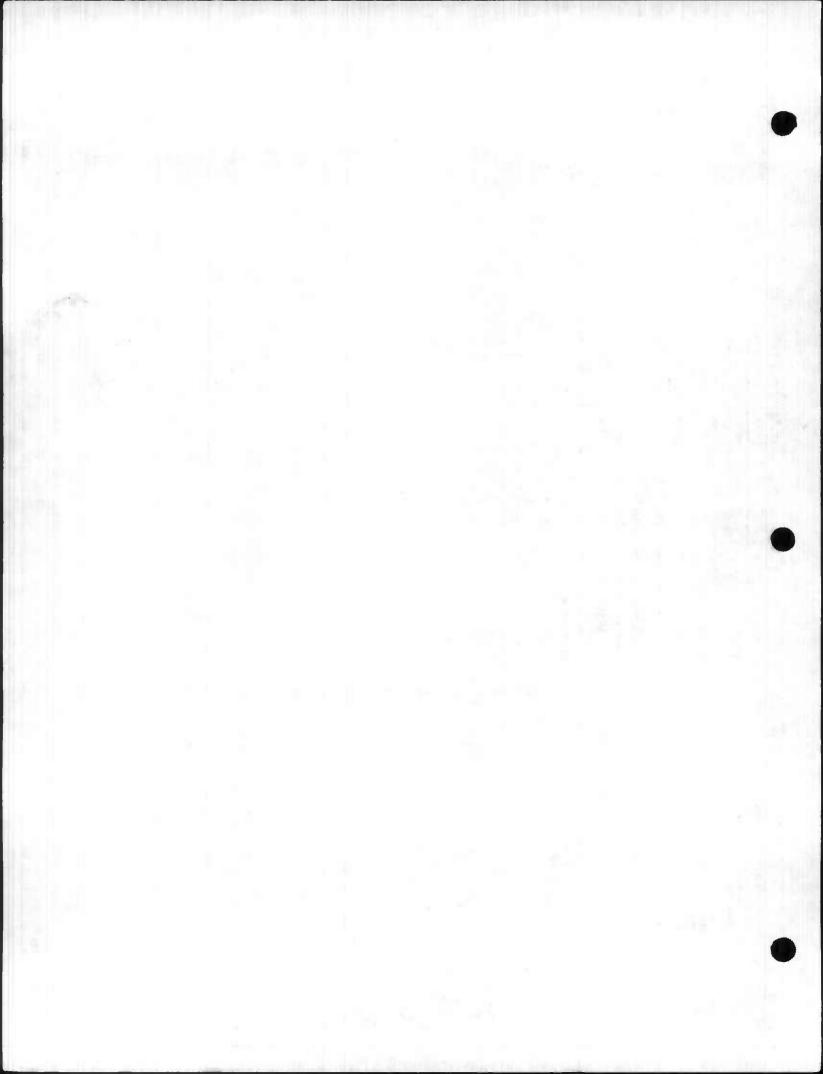
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 05 COUPLIN EONARO -EBRUARY 10 2000 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street and number) 4c. County of Death Examiner BALTO MARIS (HOSPICE) MERCY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months 12M 20 F Hours 212-58-683 Director Usual Residence of Decedent tOd. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location show 1 Yes 2 □ No BA CTO Director MD 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23s or USA 21218 KOBL 2017 Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Meritel Stetus Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married 1 Yes 2 No 21215-0020 8 1 Yes 2 No Specify 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) UNEMPLOYE 12 GRAde NA Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) 88 Pages 1 and 2 should be nent of Health and Mental JOHN COUPLIN MAITH LILLIAN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an important: If Item 27 is a any injury or other trau BARBARA mo 21218 BALTO. 2009 Robb 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete 20e. Methød of Disposition cemetery, cremetory or other piece) 1 ■ Burlel 2 □ Cremation 3 □ Removel from State 2/14 LANSDOWNE ZION CEM. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
BETTS FUNERAL HoinE 21. Signeture of Funeral Service Licensee BALTO 1129 N. CAROLINE ST roma 21213 23a Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or heart feiture. List only one cause on each line. Approximeta Intervet Between Onset end Deeth **Physician** /Medical Immediate Cause (Finat disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner The law requires that the death certificate be executed and Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of) Box 68760, Physician/Medicai Due to (or es a consequence of): 88 P.O. Pert It. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 500 1 Yes 2 No Division of Vital or Attending Physicien: 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) STE // A MARIS Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpicit Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28e. Date of Injury (Month, Day Year) 5 Pending investigation Neturet 1 Yas 2 No 24 hours after death.

Funeral Director: A 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. within 2 29b. Signeture And title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 4 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAUID RISEBER9. 30/ St YISEBERG 31. Dete filed (Month, Dey, Year) FEB 15 32. Registrer's Signeture State 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death YRONE NORMAN CARTER FEBRUARY 13, 2000

4b. City, Town, or Location of Death

BALTIMORE

3. Time of Death

4c. County of Death

29d. Dete signed (Month, Day, Year)

M.D. - 21239

FEBRUARY 13, 2000

BALTIMORE

7:05 AM

Physician /Medical Examiner **Funeral** Director Director 288-1 b 238 Baitimore, Maryland 21215-0020 8 þ Completed permit. Pages 1 and 2 should be lited within Department of Health and Mental Hyglens. Important: If Item 27 is marked other than "1 any Injury or other traumetic event, the Mag Be **Physician**

/Medical **Examiner** The law requires that the death certificate be executed buriel-transit page 2 should be or Attending Physician: funeral director. this Affer after death. filled in by 24 hours a Funeral D completely To the I

Box 68760. Physician/Medical P.O. Records, þ Completed Division of Vital Be Certification: To Medical 29b. Signature and title of certifier

GOOD SAMARITAN HOSPITAL 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 3/2/ Birthplace (State or Foreign Country) Days Hours 48 Usual Residence of Decedent Yrs. MP. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD BALTO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 CASTLE USA 601 N. 57 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus 1 Yes 2 No 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BALTO C11 WASTE So Lid 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NORMAN Thompson RAY UDREY 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUDREY RAY 601 N. CASTLE BACTO 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 2/18/00 BALTO, MD ARBUTUS MEM. PK 4 ☐ Donation & Other (Specify) BETTS FUNERAL HomE BALT. 21. Signature of Fungral Service Licensee 22. Name and Address of Facility 1129 N. CAROLINE ST 2/2/3 ul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disaasa or condition resulting in deeth) SEPSIS Due to (or as a consequence of): LEFT LOWER LOBE PNEUMONIA Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Munknown CONGESTIVE HGART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ANOXIC BRAIN INJURY 1 Yes 2 No OBSTRUCTIVE PULMONARY DISERVE CHRONIC 25. Was case refarred to medical 26. Place of Death (Check only one) examinar? Hospitel: 12 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Neturel 5 Panding 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

State

Registrar

29e. Certifier (Check only one)

Anuag

ANURAC

31. Dete filed (Month, Dey, Year) 15

4a Facility Neme (If not institution, give street and number)

CUPTA, M.D. 32. Registrar's Signature

M.D

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

ANILODA GIDTA M.D. 5601 LOCH RAVEN BOULEVARD, BALTIMORE

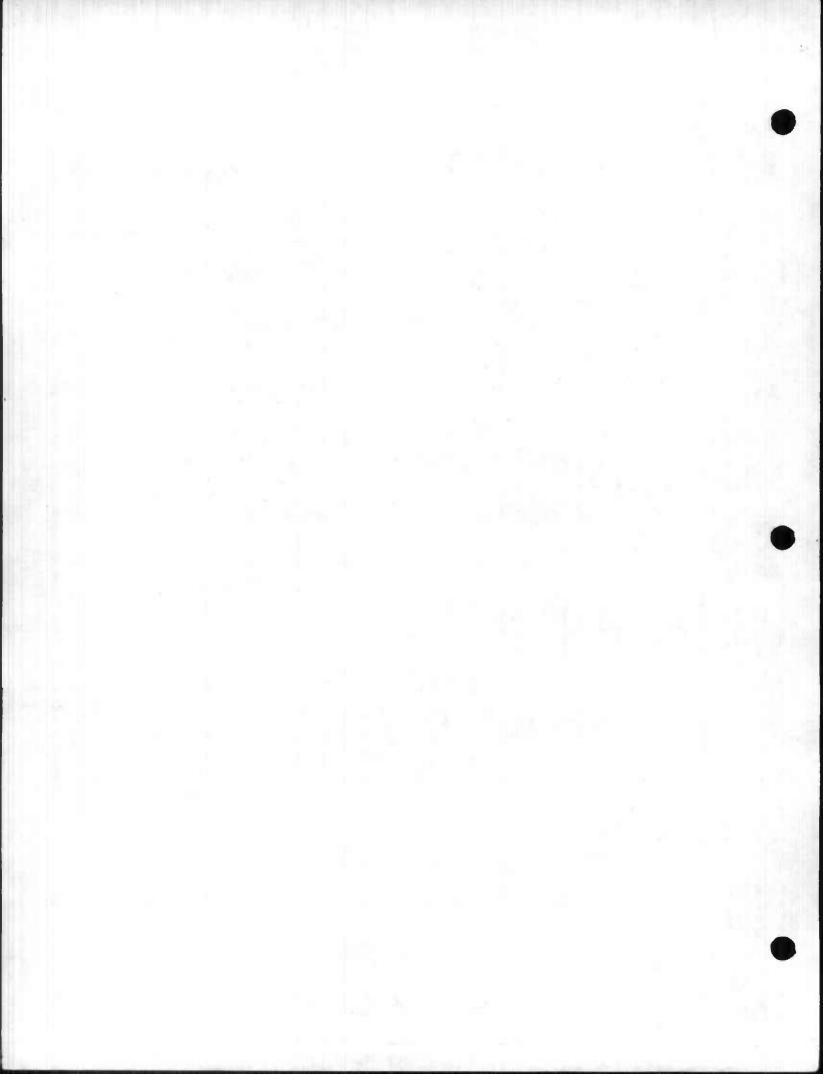
M.D. - 212

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29c. License number

UMP NO. 12561



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Physician BlackWELL BESSIE 11:00 AZ FEB 10 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NUrsing BALTIMER CARE Home If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | Months Days 5. Social Security Number 6. Sex 9. Birthplece (State or Foreign Country) **Funeral** 1 M 2 DE Days March 3, 1908 GENTGIA 183-20 6093 Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1. Pres 2 □ No Director NIA Marylano 10e. Street and Number BALTIMERE 10f. Zip Code 10g. Citizen of Whet Country? 1933 W. LEWINGTON Street 21123 U513 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Pages 1 and 2 should be filed within 72 hours arter of neat of Heelih and Mental hygiene. htt: If Iem 27 Ie marked other than "neture", or lean ary or other traumate event, the Medical Estation. Bleck, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ÊNo Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hutzlers DEpt. Elementary/Secondary (0-12) College (1-4or 5+) SCRUICE Worker # grade Store 0 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen BOWMAN KUEBUCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/3 KENYOW AVE JERALd 3318 BOLYMUN Marylow 1/GYANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 Cremation 3 Removel from State -16-2000 ArBUTUS, permit. Page Department of Important: If any Injury or once. Mary lows 4 □ Donation 5 □ Other (Specify) Momortal 22. Name and Address of Fecility CHATM AN - HARRIS TOKAS Here 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. **Approximate** Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Cerebra Vosular disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine Jestins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? ailure. 170 Deculity ules 1 | Yaa 2 | No 3 | Probably 4 M Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to medicat examiner? 88 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA # 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? After or Attending To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSHANS. SALUAM 1600 W. MOUNTROYOR Are, Bull- MD 2/2/17 31. Date filed (Month, Day, Year) FEB 15

29b. Signature and the of certified

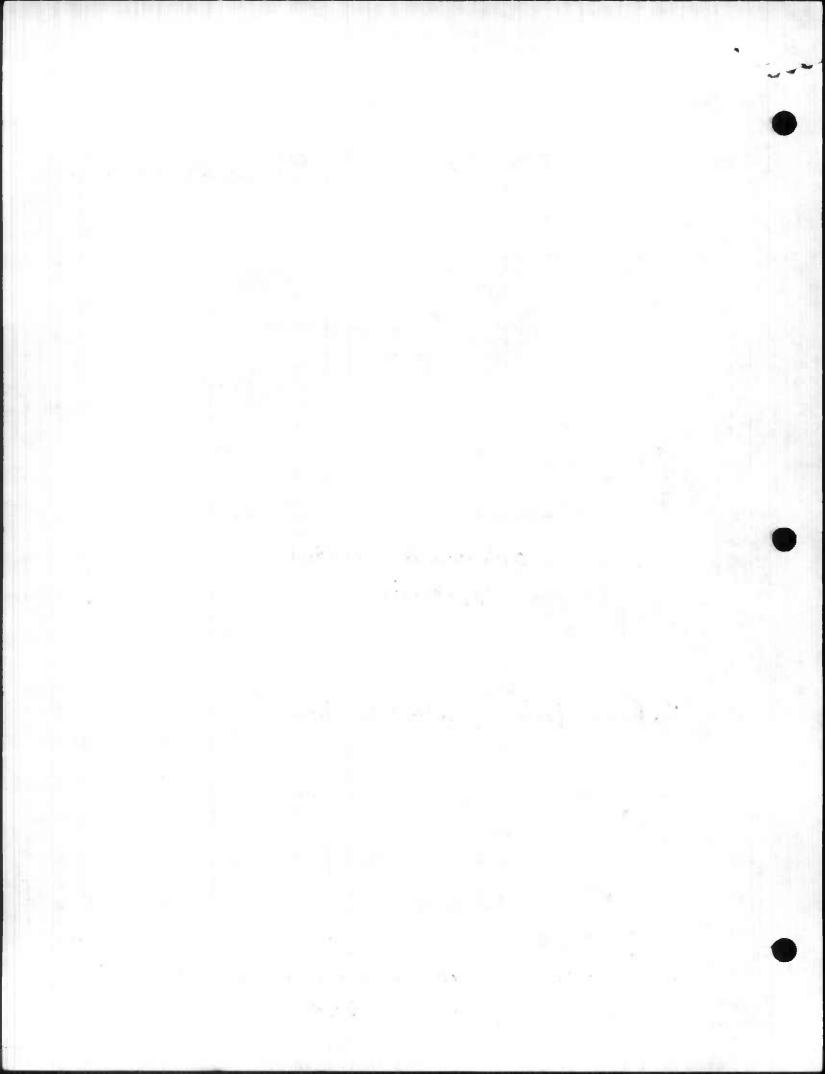
32. Registrar's Signature

oorks

29c. License number

D17537

29d. Date signed (Month, Day, Year)

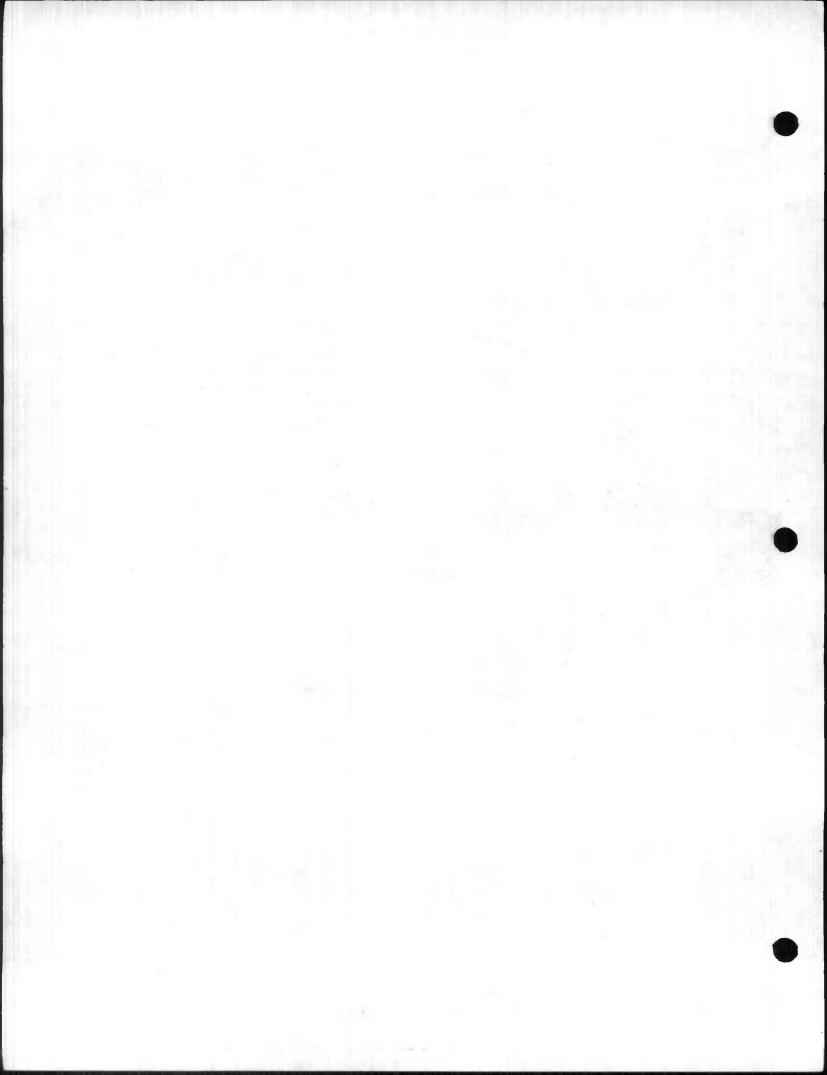


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 6, George Edgar Cumberland Feb. 2000 2:50 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11813 Cedar Lane Kingsville Baltimore H Under If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 10 M 2□ F Yes Director 212-09-5686 80 Aug. 26, 1919 Baltimore.MD Usual Residence of Decedent flied within 72 hours efter deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo ms 23a or 28a-f Maryland Baltimore Kingsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11813 Cedar Lane 21087 U.S.A. Funeral Neme : 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-ll Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status r than "natural", or han Black, White, etc. 1 (X) Yes 2 No ARMY If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: þ 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 and 2 should be filled within nent of Haaith end Mental Hyglena. mt: if Itam 27 is marked other than iry or other treumstic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 11 yrs. Elevator Mechanic Elevator Industry n/a Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Henry Cumberland Catherine Marie Nay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David T. Cumberland 9008 Chesapeake Avenue Baltimore, MD. 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State pemit. Pege Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Grdns. 2/9/2000 Fallston, MD. 21047 21. Signature of Funeral Service Lip 22. Name and Address of Facility E.F.Lassahn Funeral Home 11750 Belair Road 12 Kingsville, MD, 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician letastalie Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed the burlet-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical Due to (or as a consequence of): . for use P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? pege 2 After this cartificate has 1 Yes 20 No 1 ☐ Yes 2 ☐ No or Attending Physicien: funaral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 119 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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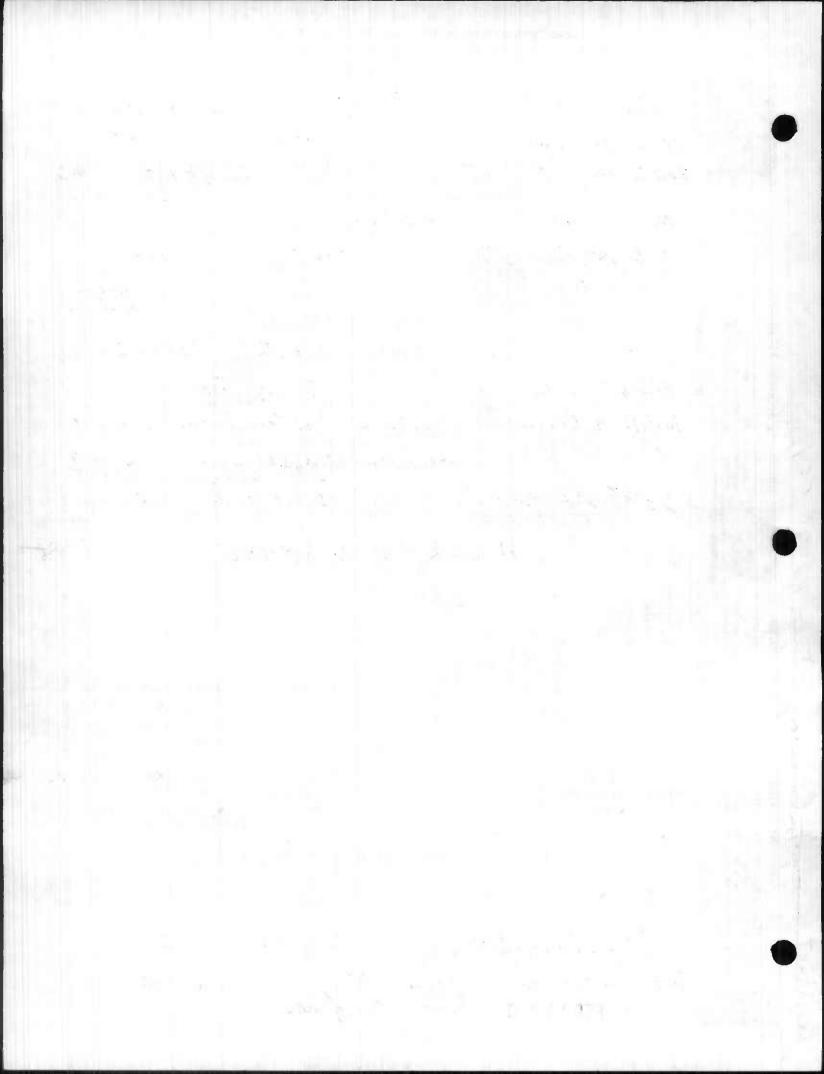


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth CONWA Month Year **Physician** 6:04AM EIGHHUN 2000 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** BALTimore Royal 8. Sex ZZZC pMf. 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) if Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□ F Months Days 220-26-2166 Yrs. MID Director Emmy 16, 1933 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location flem 27 is marked other than "natural", or flems 23s or 25s-f show other traumatic event, the Medical Examiner must be notified at Yes 2□ No Director BALTimore MyD 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 21217 12. Wes Decedent Ever in U.S.
Armed Forces?
1 | Yes 2 | No
If Yes, Give 2226 Funeral death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-il Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American indien, 11. Marital Status Biack, White, etc. 2 Married Specity: African 1 Never Married 1 □ Yes 2 □ 106 Specify: þ 3 ☐ Widowed 4 ☐ Divorced American Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mentel Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Steel Company raclor NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 6 Elwood Vaisey JONES CONWAY 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Wife permit. Pages 1 and 2 : Department of Health ar Important: If Item 27 is any Injury or other trau Conway Judith A. Terr. Ballimore, MD. 21217 2226 ROYAL 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 Deburial 2 ☐ Cremation 3 ☐ Removal from Stete Mem Garde Library 142000 Sahber □ Donation 5 □ Other (Specify) 638 N. Gilmon Stee 21. Signature of Funerel Servica Ligit 22. Name and Address of Facility 23a. Part1. Enter the disease, or coopelications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart fellure. List only one cause on each line. BALT, movemo 21217 Approximete Interval Between Onset and Deeth **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): attending physician for usa as the burie Physician/Medical Due to (or as a consequenca of): been signed by the atte should be detached for Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 28 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was en eutopsy Completed 1 Yes 20 No 1 ☐ Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 24 hours aftar deet Funeral Director: 6 Could not be 3 Suicide 28e. Pieca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ŏ 1 Cartifying Physicfan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 24 To the F 29d, Date signed (Month, Day, Year) 29b. Signature end title of cartifier 29c. License number 2,10,00 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) N. EUTAW SALTIMORE NO 2120 KRISHNAN ST #305 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 15 Registrar 9HMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Deta of Death FERNALY 10, 2000 DIRAULA SALVATOR 1256PM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTOWN BALTIMORE NIRTHWEST HOSPITAL 7. Age (In yrs. last birthday) | ff Under 1 Year | ff Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foreign Country) 1QM 2□ F 213-07-5438 Feb. 8 1913 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location **Baltimore** Owings Mills 1 ☐ Yas 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5016 Stone Shop Circle 21117 USA 12. Was Decedent Evar in U,S.
Armed Forces?
1 Yas 2 XNo
If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Pipe Fitter n/a 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Frank DiPaula Adelina DiPaula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salvatore A. DiPaula, Jr./Son 97 Westview Dr., Shrewsbury, PA 17361 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 2/14/00 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD

22. Nama and Addrass of Facility

Lemmon Funeral Home

10 W. Padonia Rd.,

Physician

/Medical

Examiner

10a Stata

MD

Director

Funeral

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Completed

88

Funeral

Director

28e-f

na 23a or

with the Maryland

filed within 72 hours after

Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H ant: If them 27 is marked off lury or other traumatic even

Department of Important: If any injury or

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Physician/Medical

physician and the burial-transit After this certificate has

P.O. Division of Vital Records, or Attanding Physician: To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af filled in by completely

The law requires that the death certificate be assouted Box 68760,

DHMH 16 Rev 6/95

Registrar

Medical Certification: To Be Completed by

Michael 12 Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final diseasa or condition resulting in death) RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initieted events rasulting in death) Last

21. Signeture of Superplacervice Licomas

Due to (or as e consequence of):

NTERSTITIAL LUNG DISEASE ASBESTOSIS Dua to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, CAD, CABG

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yas 2 No 1 Yas

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 TUnknown

Timonium, MD 21093

Approximate Interval Between Onset and Death

10 DAYS

YEARS

25. Was case rafarred to medical examiner? 26. Place of Deeth (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and place, and dua to the cause(s) and manner as stated. Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stafed. (Check only

29b. Signature and title of certifier

29c. License number 037333

29d. Data signed (Month, Day, Year) FEBRUARY 10, 2000

30. Nema and address of person who completed causa of death (Item 23a) (Type, Print)

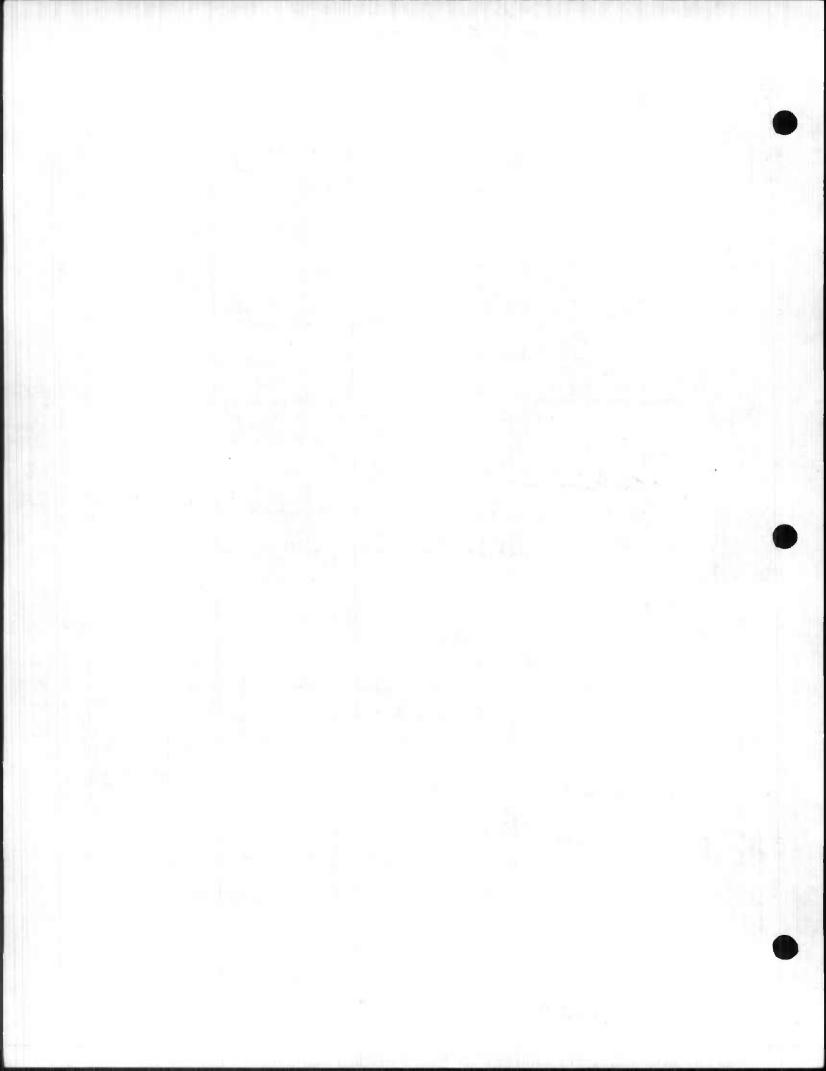
MM, NHC, C. PAVI BALTO

31. Data filed (Month, Day, Year)

FEB 1 5 2000

32. Registrer's Signatura

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] AMEND ITEMS: 22 PER F.H. G780 2-15-2000 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** DUPPINS ELIZABETH Februar LEANOR 120 7236 2000 /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUSPITAL Kaltimore NIA MAI If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex **Funeral** 1□M 2PXF Months Days 218-18-0148 Yrs. Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow BALTIMORE CI 1 No 2 No NIA Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 8 4929 Items 23s NIER AVENUE 21215 USA. Funeral 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1□Yes 2000 "natural", or Specify: BLACK Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) OWN 12 HIGRADE to ME MAKER 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 80 DANIEL GENEVA HAWKINS 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an important: If Itam 27 is any injury or other trau 635 CHARRAWAY RD. BALTIHORE, MD. 21229

20c. Location - City or Town, Stete GEORGE E. DUPPINS JR. (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete Burial 2 Cremetion 3 Removal from State 02-17-00 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) BALTIMORE NATIONAL 22. Name and Address of Fecility

22. Name and Address of Fecility

30 SEPH H, FURTON JR. FUNERAL HOME

2140 N. FUNERAL AVE., BALTO, MD. 21217

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate

Approximate Approximeta Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Ischemic Barel Examiner Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit The law requires that the death cartificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of): 8 280 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Wes an eutopsy performed? 24b. Were autopsy lindings evailable prior to completion of cause of death? Completed page 2 1 □ Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

this funaral

Box 68760, Records, P.O. of Vitai

Maryland 21215-0020

Baltimore,

JOHNS, Eleanor

8

Certification: To n 24 hours after death.

Ne Funeral Director: After th
pletaly filled in by the funeral Division or Attanding Hospital edical To the Hosp within 24 ho. To the Fune completely fi

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) FEB 1 5 2000

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL

TRISTER

5 Pending investigation

6 Could not be

2401 32. Registrar's Signeture

28a. Date of Injury (Month, Day Year)

BELVEDERE ANG. BALTIMORE, MD. 21215

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

ORIGINAL

2 ER/Outpatient 3 DOA

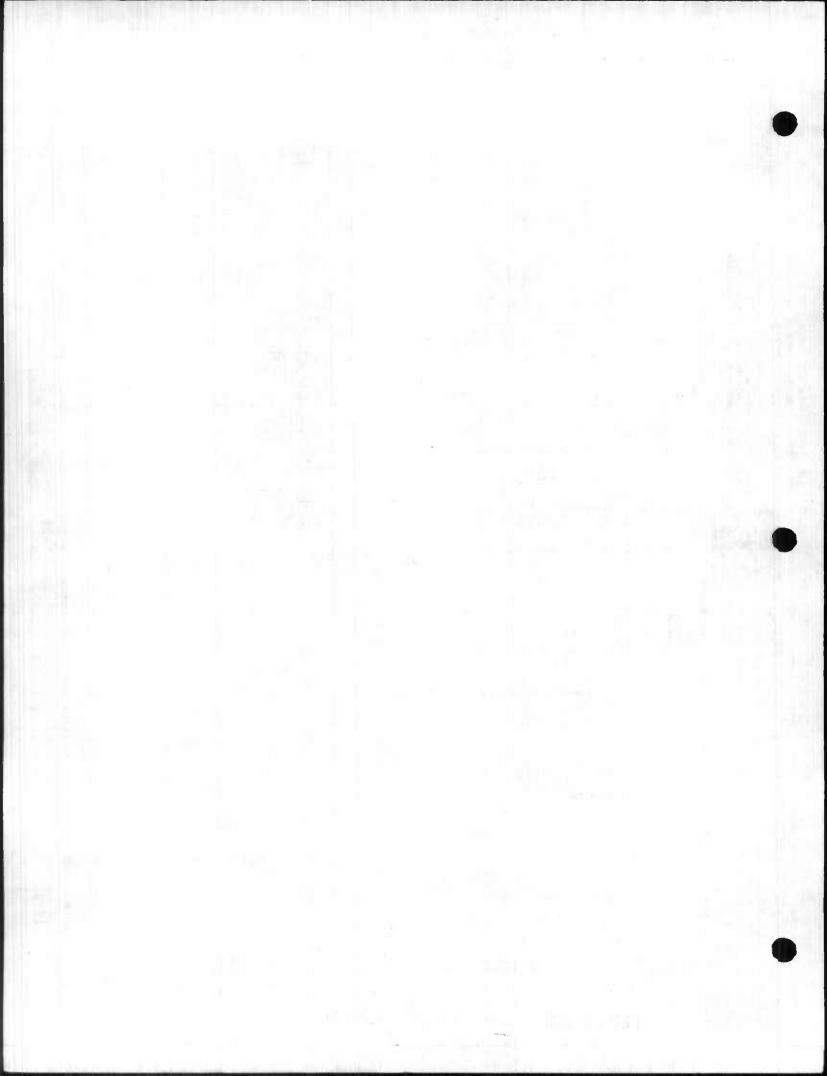
28b. Time of Injury

28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify)

29d. Dete signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month Yes Physician PY 12, FEBRUARY 2000 1:39 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, **Funeral** Months Days 10 M 25 F Hours 1-845 Director Kennsylvania Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Нетя 23а Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or frem any injury or other traumatic event, the Hedgal Exercise Bleck, White, etc. 1 Never Merried 2 Merried 1 □ Yes 2 D No Baltimore, Maryland 21215-0020 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Flementery/Secondary (0-12) College (1-4or 5+) Electri 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) HER ndermy 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnformant's Neme/Relationship (Type, Print) 20e. Method of Disposition 20b. Plece of Disposition (Name of cometery, cremetory or other p 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 □ Donation 5 □ Other (Specify) 21. Signeture of Furierel Service Licenses 21234 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediete Cause (Finel disease or condition resulting in deeth) MYOCARDIAL INFARCTION /Medical IMMEDIATE Examiner Due to (or as a consequence of): Examiner PNEUMONIA The law requires that the death certificate be executed burial-tran Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical Due to (or es a consequence of): 88 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has 1 ☐ Yes 2 No 1 Tes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Wes case referred to medical axeminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred edical Certification: 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 ☐ Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signetura and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) leh 41410 LUU V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA, M. D. , 7601 OSLER DRIVE, TOWSON MD 21204 32. Registrar's Signeture

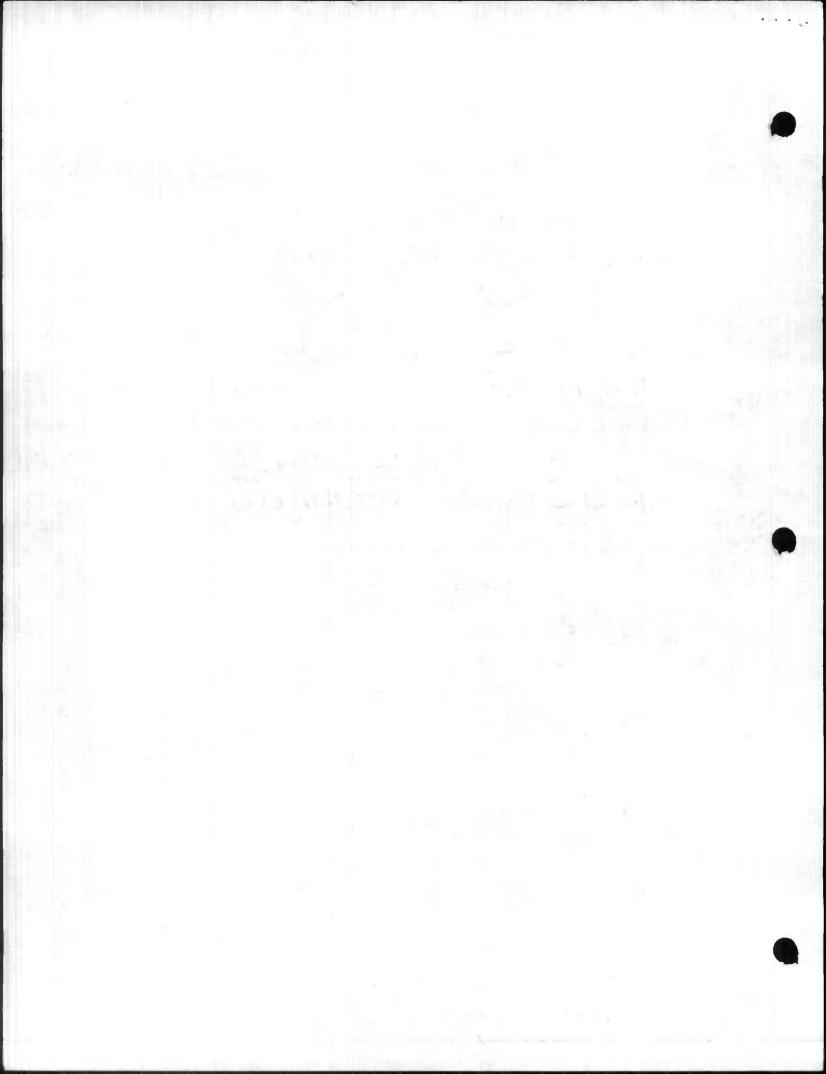
DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

FEB 1 5 2000



altimore, Maryland 21215-0020

DF LEON, RUTT

Box 68760 P.O. Records. of Vital Division

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death FEBATÜARY 007, 2000 10:10 AM **Physician** Katherine DeLeon Ruth /Medical 4a Facility Nama (If not institution, give street and number) Saint Joseph Medical Center 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours 1□M 2♥F Director 219-10-1408 Sept 3, 1918 Delaware Usuat Residence of Deceden 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or thams 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 10205 Sunny Lake Place, apt E USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Heelih and Mentel Hyglene. Important: if item 27 is marked other than "natural", or then any injury or other traumatic event, the Medical Examinations. Black, Whita, atc. 1 ☐ Yas 2 No If Yes, Giva 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify. P 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 09 Bookkeeper-Credit Department n/a 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumama) Be Warrington Hallie May Allen L. George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Robert W. DeLeon/Husband 10205 Sunny Lake Place, Cockeysville, MD 21030 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod ot Disposition Deta 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 2/9/00 4 Donation 5 Other (Specific Lands) Baltimore-Washington Crematory Laurel, Maryland 22. Nama and Addrass of Facility By Bull Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093 23a. Part / Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician CARONIC OBSTRUCTIVE PULMONARY DISEASE YEARS /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of)
EXACERBATION Examiner physician and s the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Physician/Medical Dua to (or as a consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown HYPERTENSIVE ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE signed t þ 24b. Wara autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed page 2 Attending Physician: 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yas 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Hospital or Attending
 24 hours efter death.
 Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28t. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of tnjury - At homa, tarm, street, tactory, office building, etc. (Specify) 2 4 Homicide filled in t 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier To the Mosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) atividad D. de Seen, mot. D 19508 12000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NATIVIDAD D. DELEON, M.D., 76Ø1 OSLER DRIVE TOWSON, MARYLAND 212Ø4

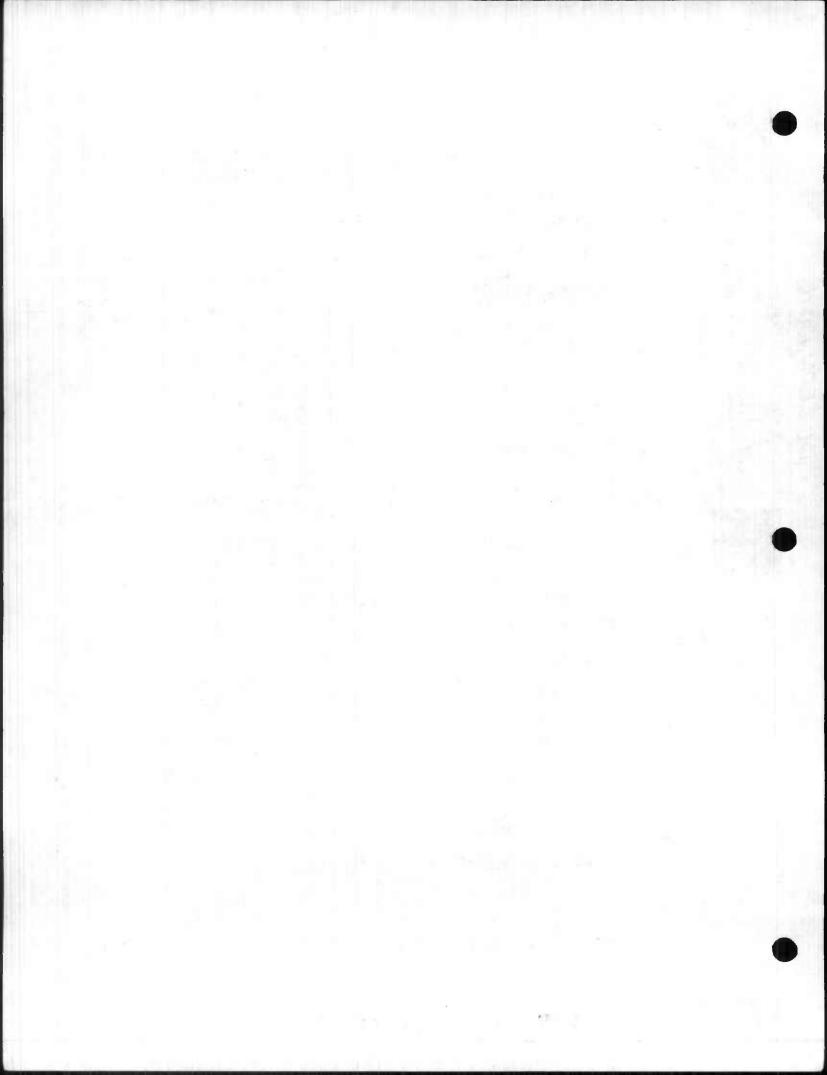
Please Type or Print In Black Indeiible Ink. Assure All Coples Are Legible.

DHMH 16 Rev 6/95

State Registrar

31. Data filed (Month, Day, Year)

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** mna raola :23 pm -eb 12 00 /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County Ceneral Hospita -olumba toward If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2QF Yrs. **Director** 219-22-1057 31, 1927 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Howard Woodstock Director or 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2100 Ganton Green, Unit 103 21163 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Yeer or Detes: ò 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementery/Secondary (0-12) College (1-4or 5+) High School Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Louis Heim Margaret Nichol of Health and N Nam 27 is man 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudolph DePaola/husband 2100 Ganton Green, Unit 103 Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a, Method of Disposition Date Department of I 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8 Metro Crematory, Inc. 2/14/00 Baltimore, 22. Name and Address of Fecility Cremation Society of Maryland, Inc. 21. Signature of Funerel Service Licensee lund 4 Edward A. Oregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or Det 2015101 Due to (or es e consequence of) the pidemia Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown ancreatic þ Be Completed 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? No 1 Yes 1 Yes 2 No director, 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury et Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigetion the 3 Suiclde 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical

The law requires that the death certificata be executed P.O. Box 68760, ate has been signed by page 2 should be detac Division of Vital Records, this certificate Attending Physician: After of or Attending after death. To the Hospital of within 24 hours of To the Funeral Dicompletely filled in

72 hours after

ould be filed within Mental Hygiene.

Pages 1 and 2 should

21215-0020

Maryland

Baltimore,

29e. Certifier

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only

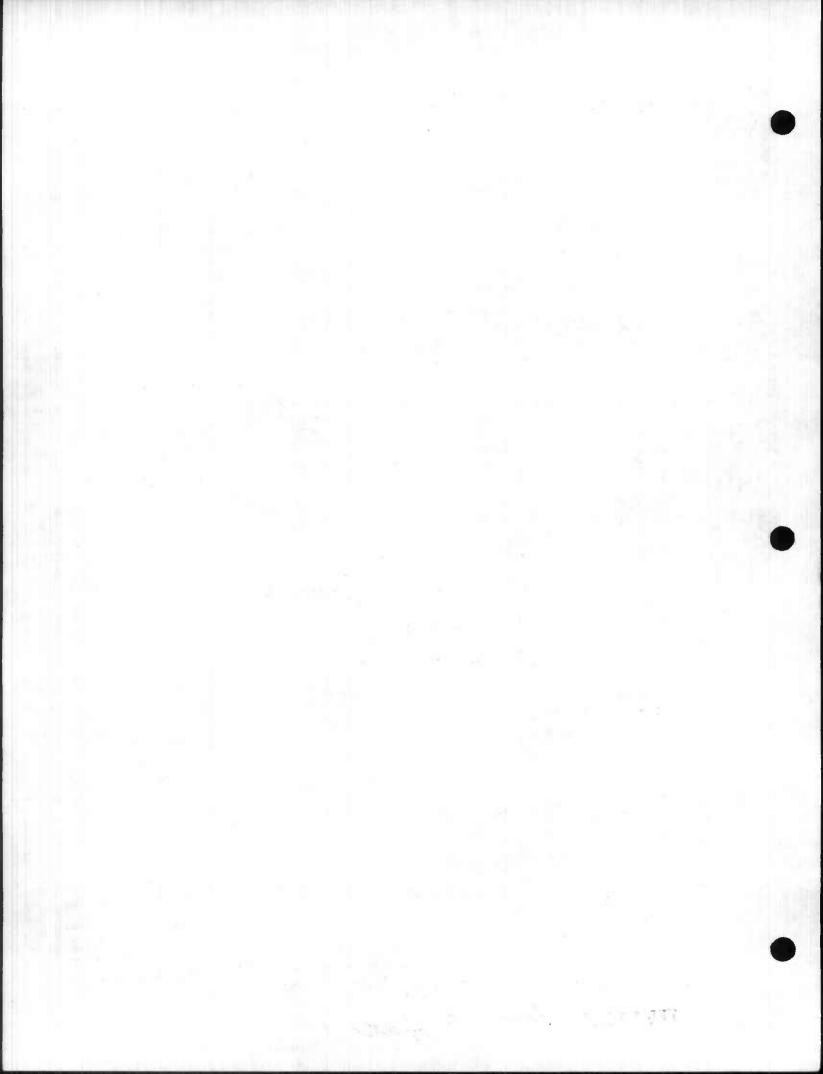
29b. Signatu and title of certific

29d. Date signed (Month, Day, Year) 29c. License number 35 21 Teb 13, 2000

30. Name and efficiess of persons completed cause of death (Item 23a) (Type, Print) vite 210 Paturent Little Columbia

31. Date filed (Month, Dey, Year) Registrar

32. Registrar's Signature



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

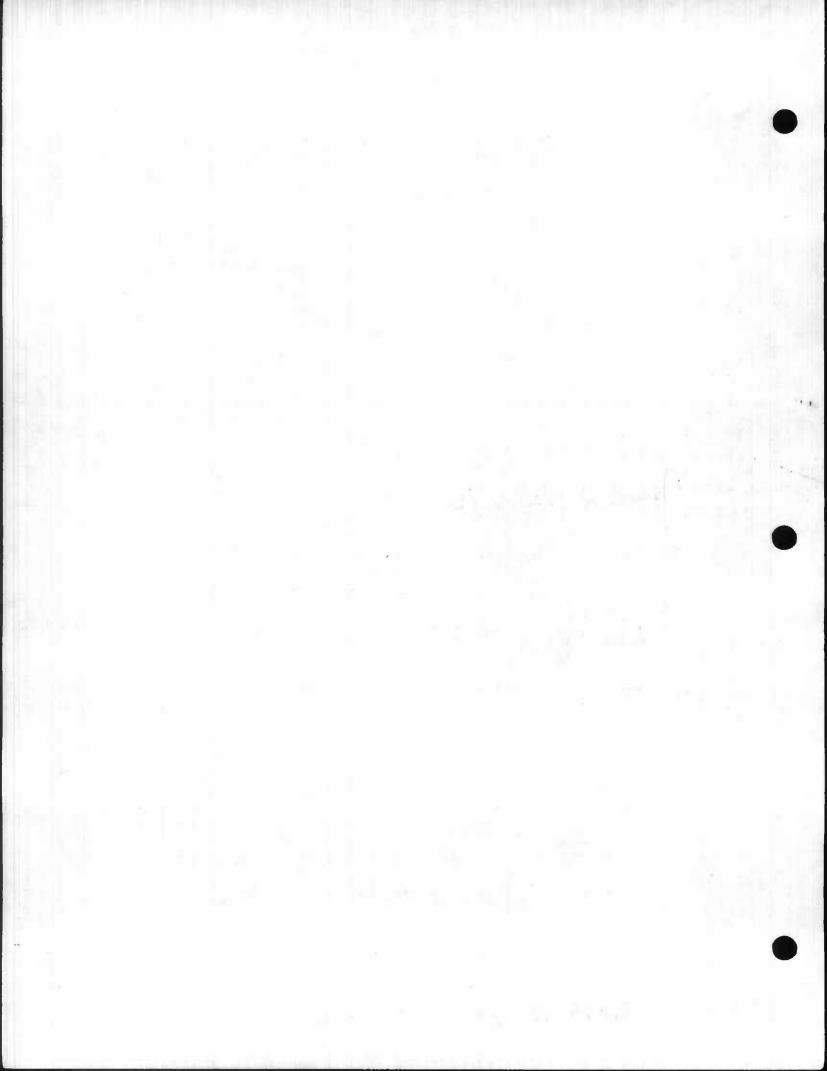
State of Maryland / Department of Health and Mental Hygienen Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** c. County of Death DAVID rebruary 11:00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner # Under 1 Year | # Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 02-08-82 HOPKINS HOSE Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1QM 2□ F 218-98-3161 17 MD Director Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD NA Baltimore 1X Yes 2 No Director 28a-1 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 2105 E. North Avenue 21213 USA Barra 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 XNo Specify: ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahouid be filed w Department of Health and Mental Hygien Important: If Item 27 is merited other th any Injury or other traumatic event Student Student llth Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul DeLilly Gloria Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 3 19a. Informant's Name/Relationship (Type, Print) Gloria Coleman 2105 E. North Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Voshell Mem. Gardens 02-11-2000 Dundalk, MD 4 Donation 5 Other (Specify) nature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 heren | WM.C.March FH 1101 E. No plant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WM.C.March FH 1101 E. North Avenue Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · MULTISYSTEM FAILURE ORGAN Examiner Due to (or as a consequence of) Examiner -RESPIRATORY certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the burial-trans Due to (or as a consequence of) Box 68760. PSIS NECK Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 80 OKEMIA MONTHS 080 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 9 2 s 1 X Yes 2 No 1 Yes 2 XNo certificate of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impetient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3 DOA this 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After t Division 5 Pending investigation 1 MNatural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D005. 30. Name and address of persol who completed cause of death (Item 23a) (Type, Print) BALTIMORE MO 21287 CHORISON SHIP C 600 N. LOOLFE 31. Date filed (Month, Day, Year) FEB 1 5 32. Registrar's Signature State

DHMH 16 Ray 6/95

Registrar

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb 1909 1.50 progret 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Howar Olum 7. Age (In yrs. last birthday) Dunty H Under 24 Hrs. 8. Date of Birth Hours Min. Sept. 20, H Mode 5. Social Security Number Year) 1921 9. Birthplace (State or Foreign Days 10 M 2 F Months Maryland 78 212-18-4565 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Woodlawn 10a Street and Number 10f Zin Code 10g. Citizen of What Country? 2024 Kennicott Road 21244 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried White 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Margaret H. Allen William Reid 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jesse Dell (Husband) 2024 Kennicott Road, Woodlawn, MD 21244 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Lake View Cemetery 2/14/00 Sykesville, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Neme end Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funerel Service Licent 1630 Edmondson Avenue, Catonsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 102/1 Due to (or as a consequence of). 1515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Tract Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Rend Insufficience

Physician /Medical Examiner

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

or Attending Physician:

To the Hospital o within 24 hours at To the Funeral D

After this

filled in by

npletely

Physician

/Medical

Funeral Director

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Examiner

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Director

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Hygiene.

Pages 1 and 2 should be 1 nent of Health and Mental I int: If them 27 is marked of

if of Health a if flam 27 is or other tra

Department of Important: If any injury or

filed within 72 hours after

21215-0020

Maryland

Baltimore,

Completed by Physician/Medical Examiner for use as the burial-transit Medical Certification: To Be s after death.
If Director: After this od in by the funeral d

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1/ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

29c. License number

State Registrar

31. Date filed (Month, Day, Year) FEB 1 5 2000

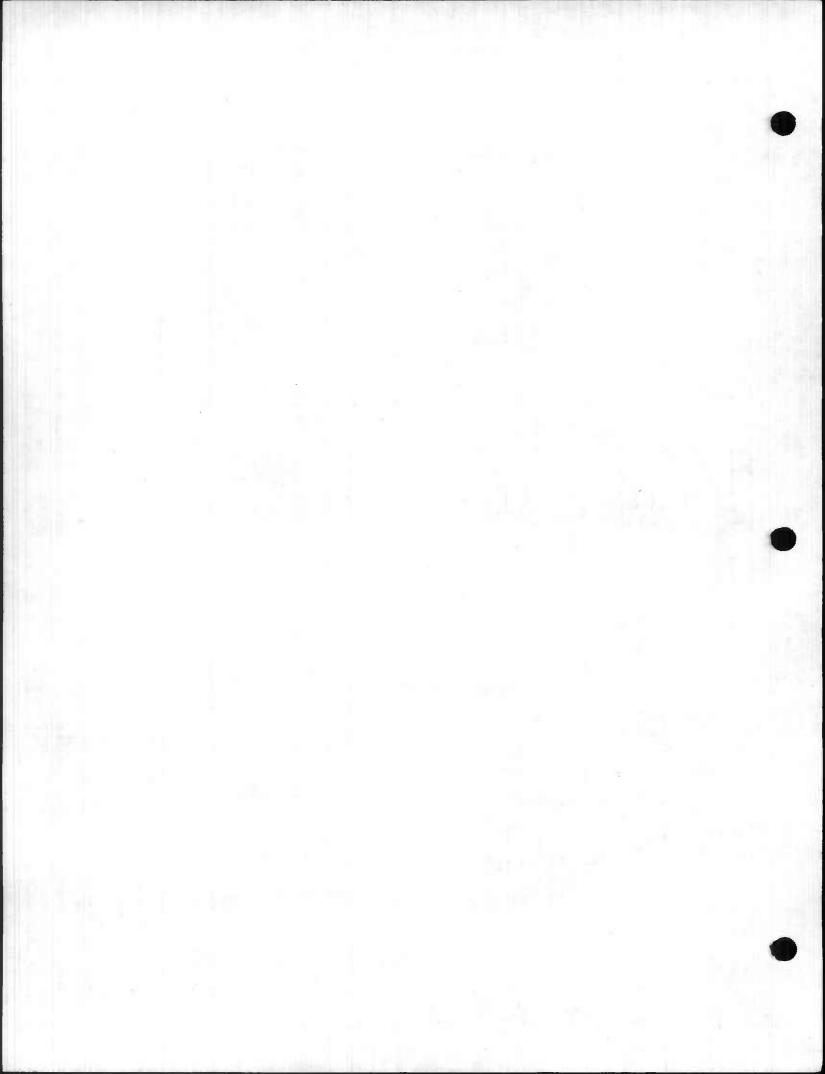
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30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signature and titlg.of-caytif

Delean

Yaky yest little 32. Registrer's Signature



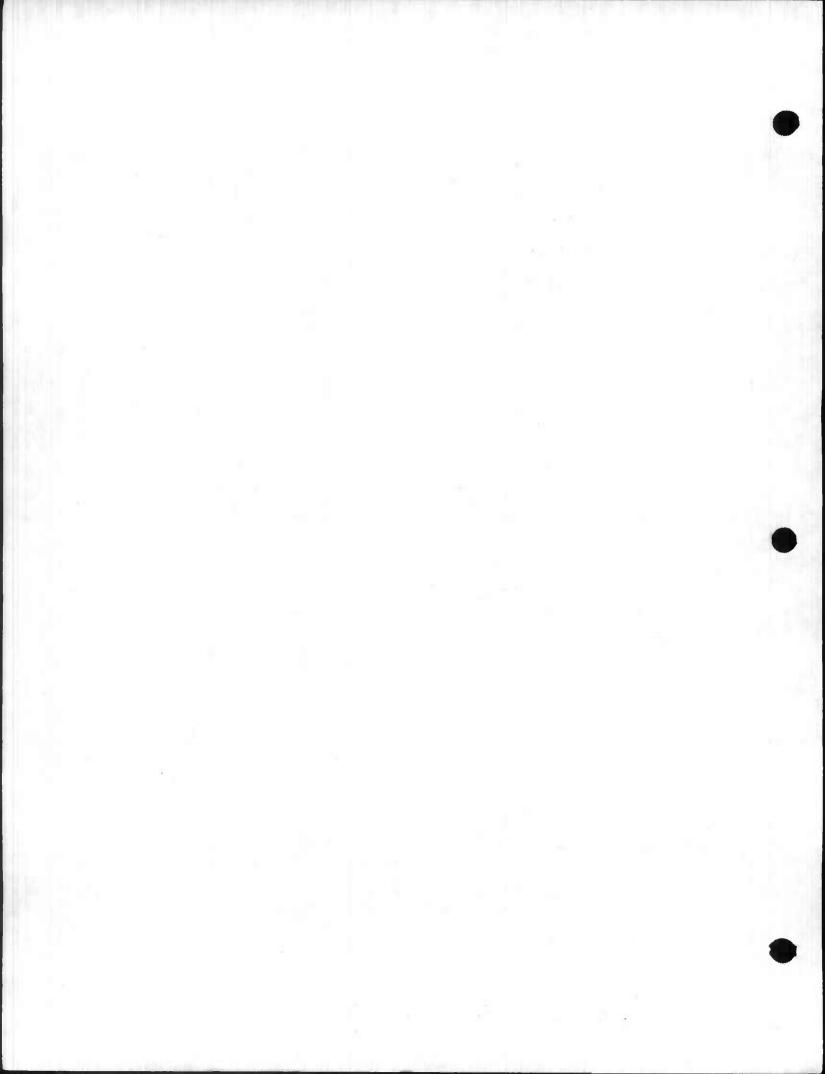
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State of Maryland / Department of Health and Mental Hygie	- 1	r
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	r 28e-f show notified at	Director	MD	BALTIMO	RE			TIMORE						1 ☐ Yes 2 ☑ No													
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	within 2 To the comple	Me	29b, Signature end	title of certifier				29c. Lic	ense numb	er	29	d. Dete sign	ed (Month	o, Day, Year)													
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State Registrar

DHMH 16 Rev 6/95

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31. Data filed (Month, Day, Year)

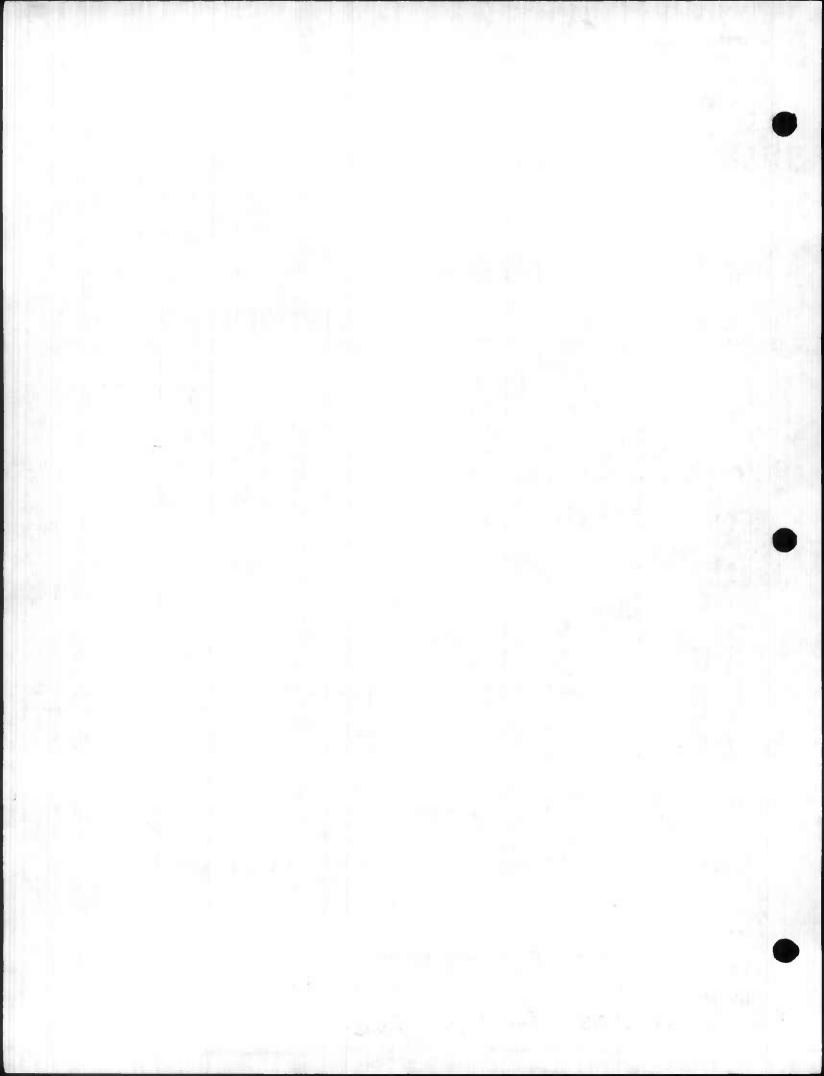
32. Registrar's Signatura

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30. Nama and address of person who complated ceusa of death (Item 25a) (Type, Print)

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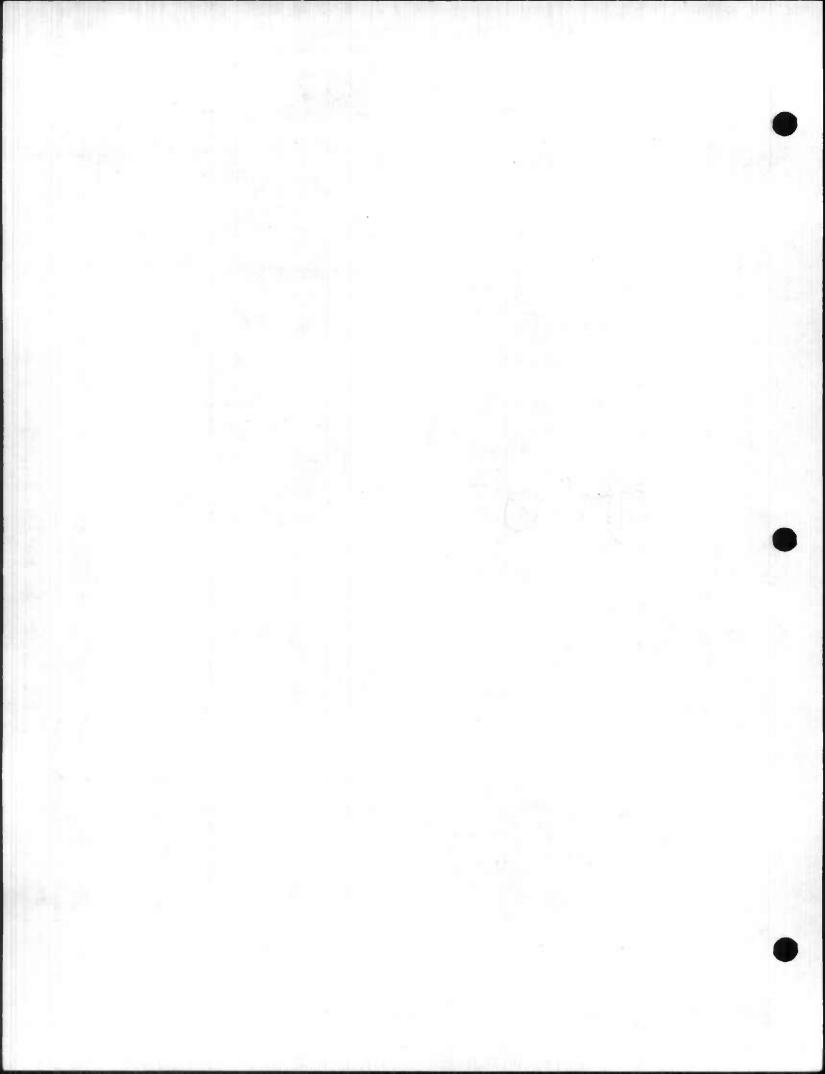
111 Penn Street, Baltimore, Maryland 21201



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State of Maryland / Department of Health and Mental Hygiene 0 0 4	2	16
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					Certificate of	Death	R	eg. No.				
61		1. Decedent's Name (First, Middle, L.	nst)				2. Date of Deat		Vans	3. Time of Death		
	Physician /Medical	Margaret VonR	ugo Belknap	Eng	lerth		Month Februar		Year 1000	7:00am		
	Examiner	4a Facility Name (If not institution, gi				4b. City, Town, or L		4c. County		7.000		
		2101 Far Out La	ne			Sparks		Balt	imore	2		
	Funeral		Sex 7. Age (In y	rs. last bir	thday) if Under 1 Yee Months Days	r If Under 24 Hrs.	8. Date of Birth	Veer)	9. Birthpl	lace (State or Foreign		
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	or 28a-fu be notifie Directo	10e. Streel and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Coun	lry?		
	23a o unit be	2101 Far Out La	no		21	152		71	SA			
	her death r thems 23 siner must	11. Merital Stelus	12. Was Decedent Ever in	U,S.	13. Was Decedent of If Yes, specify Cu		ecity Yes or No-	14. Rac	e - America			
Maryland 21215-0020	ursi', or its at Examine of by Fur		Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Detes:		If Yes, specify Cu		Rican, etc.)	Specify	ck, White, e	hite		
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a	Mental Mental rhead of fic eve	Walter Si	dney Belkn	ар		Lula		Va	ne			
ary.	45 E	19e. Informant's Name/Relationship			Mailing Address (Stree		ral Route Number			Code)		
	and 2 selfth a ser free	BeBe George, Es	a./Attorney		7 Lincoln S			21093				
re,	-116	20a. Method of Disposition		. Placa of	Disposition (Name of		7	20c. Location -	City or To	wn, State		
Baltimore,	Pages net: If its ny or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control of the Cont			y, crematory or other pl		/17/00					
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ó	EX Par	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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0	Physic rthis or rthis or rail dire	27. Manner of Death	1 ☐ Inpatient 2 28a. Dete of Injury (Month, Day Year)	ER/Ou	ime of 28c. tnj		ome 5 Reside			7		
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Division of Vital	tal or Attending P is after death. In Director: After the in by the funeration by the funeration: Certification:	3 Suicide 6 Could not b	e Ope Diese of Injun. At	home fe	m street factory office	9	28f. Location (St	treet and Numb	er or Rura	l Route Number.		
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	F 3 F 8	and the second second second second	Sandel uns			27209						
	V	Varies O	marino			21201		2/11/0	0			
	10	30. Nema and address of person who										
	W.	Patricia A. S			York Road,	suite 18,	Lutherv	ille, M	D 21	1093		
	State	31. Date filed (Month, Day, Year)	32. Registrer's Sig	natura	land.							
	Registrar	FEB 1 5 2000	Water 1	. 14	parks							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day ELDRIDGE Month Year 05A5 ELIZABETH 2000 February 03 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Northwest Hospital If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 6. Data of Birth (Month, Day, Year) Days Hours 079-05-5304 1□M ADEF 90 Yrs. Nov. 13, 1909 NY Usual Rasidence of Decedant 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 No Hampshire Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7430 Hindon Circle Apt-03 21244 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2000No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yes XX No Specify: White Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plant Paper Products 10 Machine Operator 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Edward Monnett Josephine Denaut 19e. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Eldridge 7430 Hindon Circle, Apt-103 Woodlawn MA 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 ☐ Burial 2 ☐ Cramation 3 🖾 Ramoval from Stata Notre Dame Cemetery February 15, 2000 Oswegatchie, NY 4 ☐ Donation 5 ☐ Othar (Specify) Agture of Funeral Service Liceases Victor P 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death ith. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediata Causa (Final SEPSIS disaasa or condition rasulting In death) PINGUMUZNA Sequentially list conditions, if any, laeding to immadiate cause. Entar Undarlying Cause (Disease or Injury that initioted events rasulting in death) Last Due to (of as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings svailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Department of I Important: If Ne

Physician

/Medical

Examiner

10a. Stata

MA

Funeral

Director

28a-f show

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Berns 23a

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

snt: If Nem 27 is marked other than "natural", or Ne

Hygiene.

Maryland 21215-0020

altimore,

Directo

Funeral

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Completed

Examiner a Hospital or Attanding Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Purvaral Director: After this certificate has been signed by the attending physician and leistly filled in by the furnant director, page 2 should be detached for use as the burial-transit P.O. Box 68760, Physician/Medical Division of Vital Records, þ Completed Be Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was casa rafarred to medical axaminar? Hospital: 1 Manpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No 27. Mannar of Death 28h Time of 1 Natural

28a. Data of Injury (Month, Day Year) 5 Panding invastigation 6 Could not be datamined

Plece of Injury - At home, farm, atreet, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

mann

31. Data filed (Month, Day, Year)

2 ☐ Accident

3 ☐ Suicida

29e. Certifier (Check only one)

4 Homicida

29c. License number 7 42723

29d. Data signed (Month, Day, Year) February Ogth 2000

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) HARISH AVVERAHALLI

NORTHWEST HOSPIT HOSTITAL

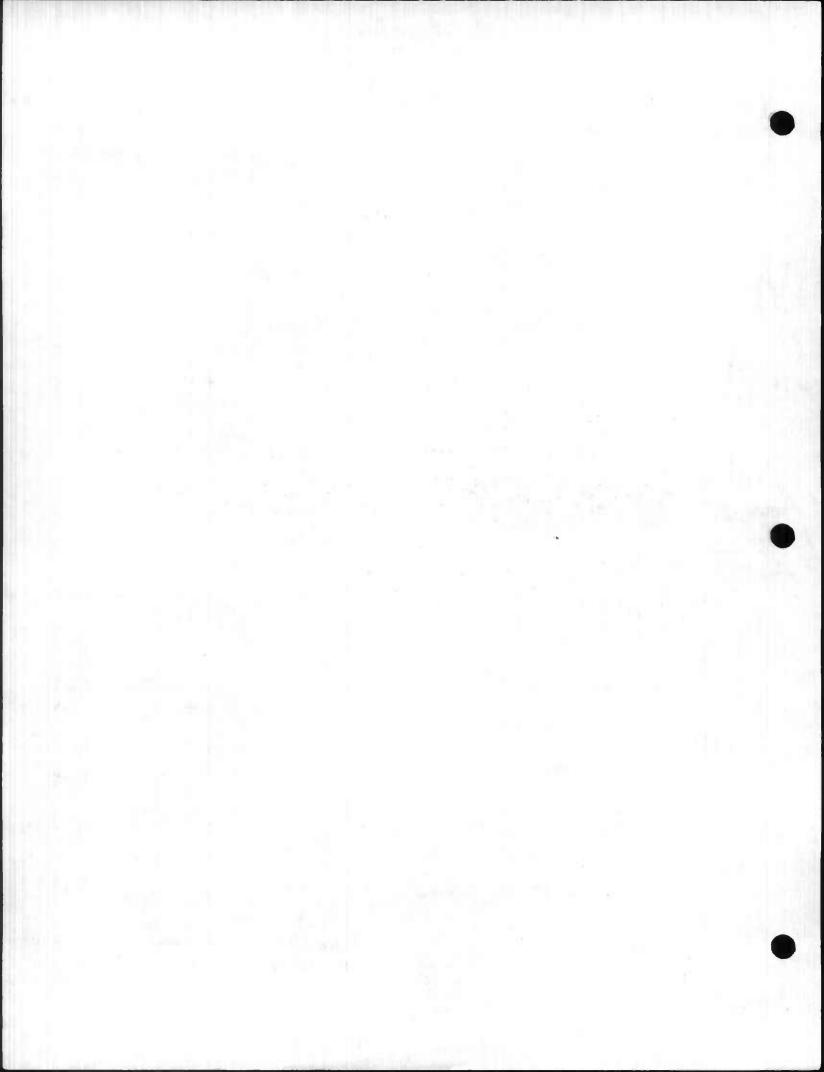
State Registrar

Medical

FEB 1 5 2000

32. Registrar'à Signatura Denewa

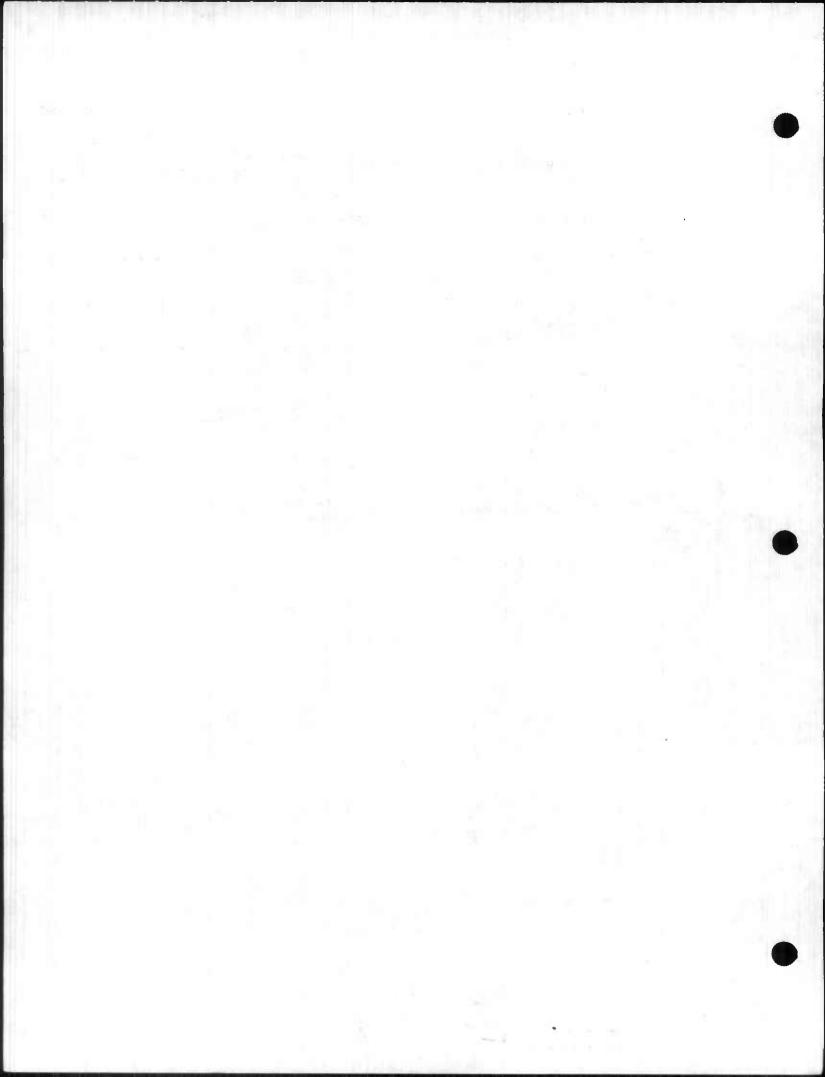
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Ocen Clerce 029085 Feb 14,20		ceense	Zenne			6	2908	-	Fer	14	2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1			leath (Item 23	Ba) (Type, Print						
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State 31. Date filed (Month, Day, Year) 32. Registrer's Signeture	State		32. Registr	er's Signeture	9	Spar					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Helen B. Eckhardt 6:40 pm February 10 2000 /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 9112 Yvonne Avenue Baltimore Nottingham Il Under 24 Hrs. Hours Min. 5. Sociel Security Number Il Under 1 Yeer 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Funeral Birthplece (Stete or Foreign Country) Days Months 1 M 200 F Director 213-03-9556 March 8, 1919 80 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Show 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at Director 1 Yes 2 No Maryland 28a-f Baltimore Nottingham 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 9112 Yvonne Avenue natural', or items 23s 21236 United States Funerai 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 0 No II Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White. Completed permit. Pages 1 and 2 should be filed within 72 Department of Health end Mental Hygiene. Important: if item 27 is marked other than "nat, any injury or other traumatic event, i'm Medical once. 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Secretary Telephone 17. Fether's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Joseph G. Nemec Katarina Moritz 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Steta, Zlp Code) Mr. George N. Eckhardt, Sr. 9112 Yvonne Avenue Baltimore, Maryland 21236 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burlet 2 □ Cremetion 3 □ Removel Irom Stete
4 □ Donation 5 □ Other (Specify) St. Joseph Church Cem. 2/14/00 Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Schimunek Funeral Home, Inc. may 1 23a. Pert1. Entar the disease, or perpositions that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest.

Maryland shock, or haart feilure. List only one ceuse on each line. 21236 Intervel Between Onset and Deeth **Physician** /Medical Immedieta Causa (Final diseese or condition resulting in deeth) ALZHEIMER'S DISEASE Examiner Physician/Medicai Examiner physician and the buriel-transit or Attanding Physician: The law requires that the death certificata be executed Sequantially list conditions, if eny, leeding to immediata cause. Enter Underlying Ceusa (Diseese or Injury that initiated evants resulting in deeth) Lest Dua to (or es e consequance of) Box 68760. Due to (or as a consequence of): ettending p for usa as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco usa contribute to the cause of death? MULTI-INFARCT DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware eutopsy findings aveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? page 2 1 Yes 2 No 1 Yes 2 No Be 25. Was cese referred to medical exeminar? 28. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this the funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 1 Naturel 2 Accident 5 Pending Investigation To the Hospital or Attandir within 24 hours after daath, To the Funeral Director: A 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 1 Cartifying Physician: To the best of my knowledga, daath occurred at tha tima, dete end placa, and due to the ceusa(s) and manner es steted.
2 Medical Examinar: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end manner steted. 29a. Cartifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Walledi un D-12849 2-11-00 30. Name and address of person who complated cause of daeth (Item 23e) (Type, Print)

7600 OSLER Dr. TOWSON, Md. 21204

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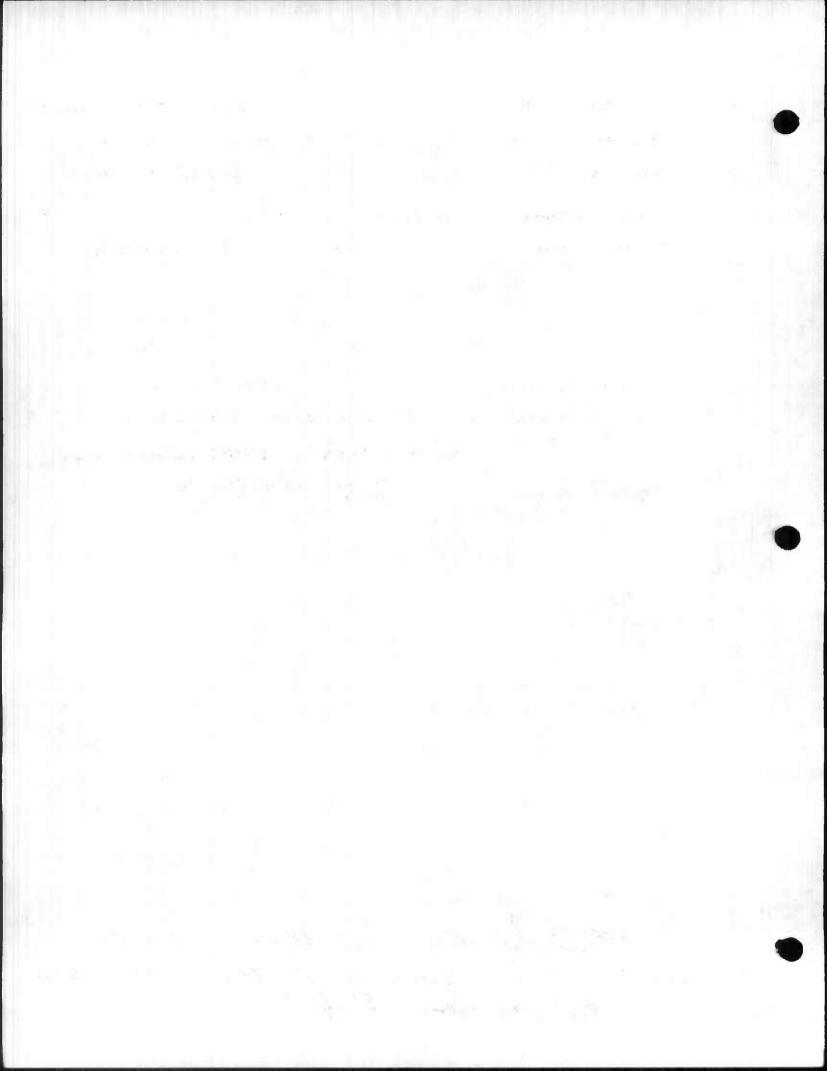
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31. Date filed (Month, Day, Year)

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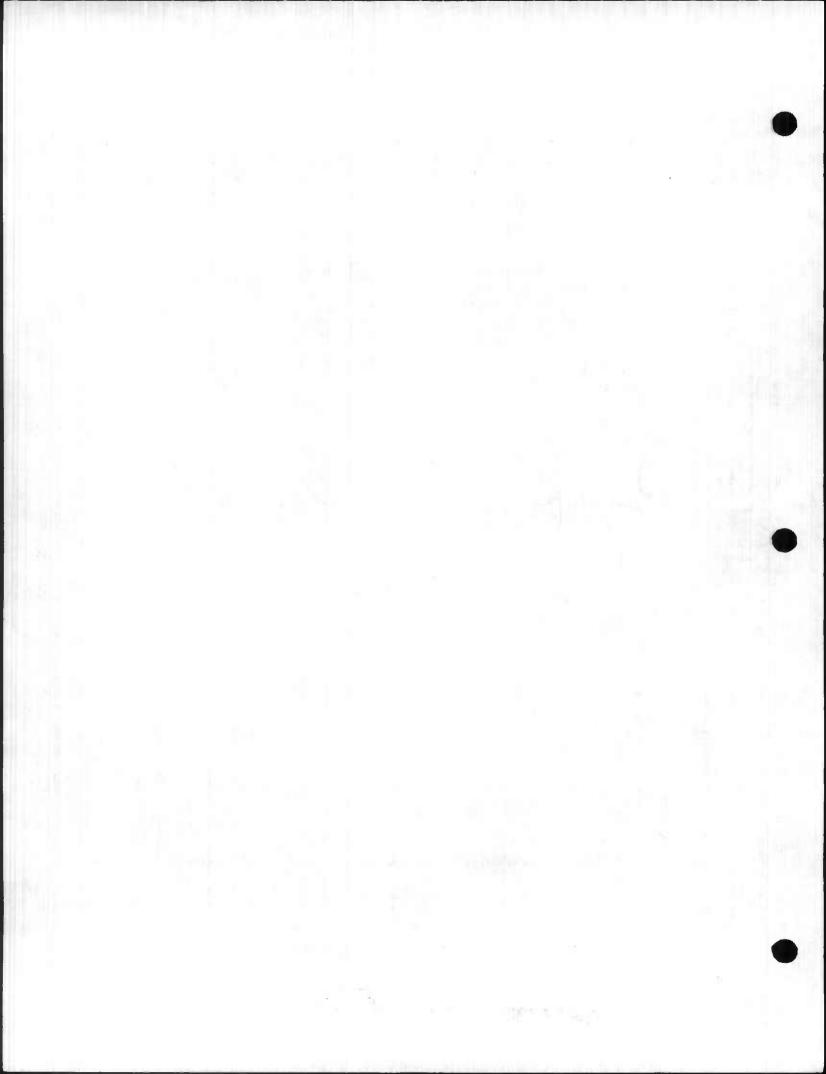
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 13, 2000 9:00 P.M. Peter Efinchuk /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk Heritage Center/ Genesis Elder Care If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days Min. tXOM 2□F Hours Director 023-22-6879 78 23. 1921 Massachusetts Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 □ No Director Maruland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b flems 23s 4636 Parkside Drive 21206 U. S. A.

14. Race - American Indian,
Black, White, etc. Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 by Yes 2 No
1f Yes, Give
Year or Dates 1940-1962 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1♥ Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiece. Other then 'n Elementary/Secondery (0-12) College (1-4or 5+) 11th Grade Security Guard Pentagon permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If Item 27 is marked other I any Injury or other traumatic event. It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Efinchuk Mary Yankowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbar Schramm (Guardian) 10 Elinor Avenue, Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery
Garuson Forest 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Permoval from State 4 Donation 5 Other (Specify) Owings Mills. Maryland 22. Name and Address of Facility
Schimunek Funeral Home Inc. 21. Signature of Funeral Service Lic tus 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or e-implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner vascular diseuse brere ician and burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con physician sthe burial Box 68760. Physician/Medical Due to (or as a consequence of): 88 080 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? ASCVI) 1 Yes 2 No 3 Probably 4 TUnknown Records, à The law requires 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed page 2 a 1 ☐ Yes 2 Ø No 1 ☐ Yas 2 ☐ No Division of Vital or Attanding Physician: 25. Was case reterred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residenca 8 Other (Specify) 1 Yes 2 J-N6 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? After 1 Naturat 5 Pending 1 Yes 2 No death. investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Sulcide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of forther 29d. Date signed (Month, Day, Year) mo 30. Neme and address of person who co impleted cause of death (Item 23a) (Type, Print) dilen 1838 Greene Tree ld leman 31. Date tiled (Month, Day, Year) 32. Registrar's Signature 2000 FEB Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND 16a&19b PER F.H. #28c PER MD. G780 2-15-2000 J.A Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mitchell Louis Frances, Jr. 7:00 P.M. 4, Feb. 2000 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7811 St. Claire Lane Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Md. **Funeral** 1☐M 2□ F Yrs. Director 220-20-2650 72 Usual Residence of Decedent with the Maryland 10a. State "natural", or items 23a or 28a-f show soical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Director Dundalk/North Point 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7811 St. Claire Lane 21222 U.S.A. death Funeral 12. Was Deceden! Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status filed within 72 hours after 1 Never Merried 2 Married 1 Yes 2 No Specify: Completed by SpecifyWhite 3 N Widowed 4 Divorced The Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) EXPEDITER College (1-4or 5+) Production Exp Steel Co. permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Item 27 is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mitchell Louis Frances, Sr. Catherine Westbrook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 9429 Kilbride Ct., Perry Ha;;, Md/.21128 Barbara Martin / Daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 № Burial 2 X Cremation 3 Removal from State Balto-Wash. Crematory 2-8-00 Laurel, Md. 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility rvice Licensee m00933 Bradley-Ashton-Matthews Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approx Physician Immediate Cause (Final disease or condition resulting in death) /Medical CORONARY HEART DISEASE 8. Examiner Due to (or as a consequence of): Physician/Medical Examiner DIABETES MELLITUS & Newsopath M II The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury COP 10 18 that initiated events resulting in death) Last Due to (or as a consequenca of):

Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Part I.

HYPERCHOLESTEROLEMIA

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown

24a. Was an eutopsy performed?

24b. Were eutopsy findings evailable prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending Investigation 1 MNatural

28c. Injury et Work?

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

þ 90

Completed

Be

2

Certification:

Medical

certificate has

tha funerai

filled in by

To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier Lult, mo.

6 Could not be determined

29c. License number DD016306 29d. Date signed (Month, Day, Year) 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) A. C. CHOLVALIT, MD

BALTO, MD 21231 98 N. BROADWAY, SUITE 306

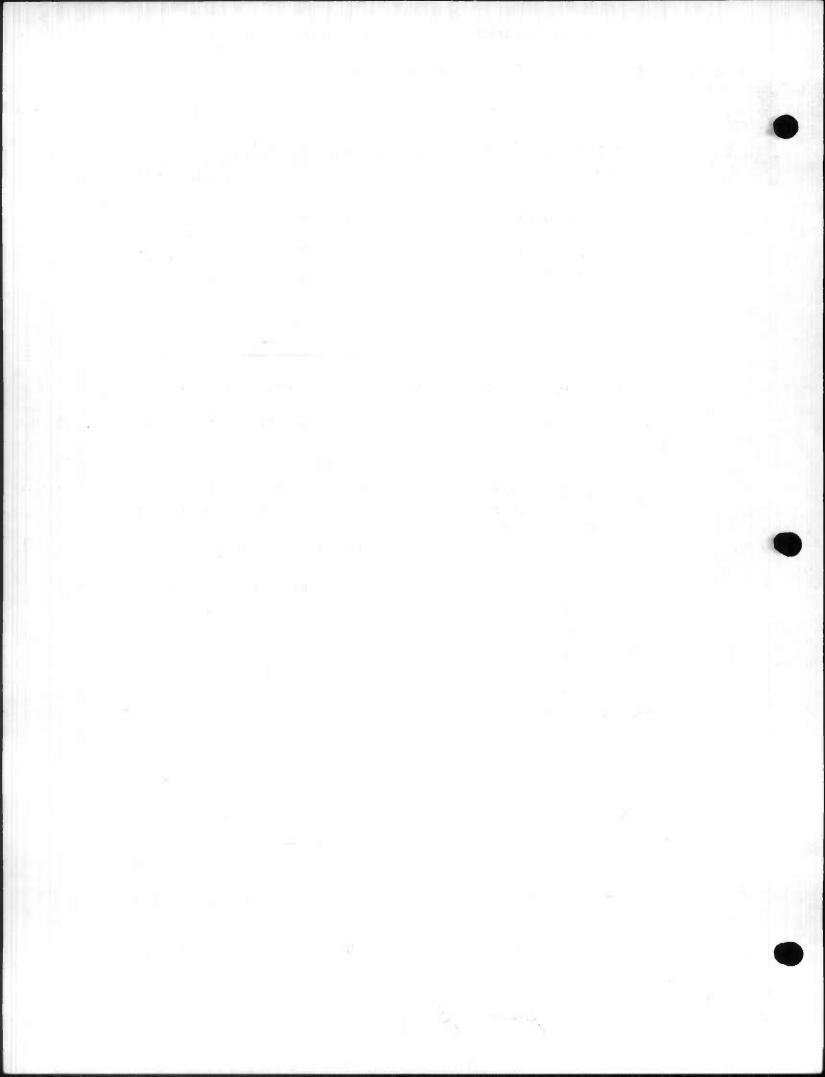
State Registrar 31. Date filed (Month, Day, Year) FEB 1 5 2000

32. Registrar's Signature

Baltlmore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 1:48 PM Fitzgerald Ame S 2000 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Good Sernaratu Hospital ER Baltmoxe Belbuneke If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (Steta or Foreign Country) **Funeral** 1XM 20 F Months 68 225-36-4420 Yrs. Director Usuel Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits r then "natural", or items 23s or 28s-f show The Medical Examinar must be notified at MD Be (timore e 1 Yes 2 No Director 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21213 Clifmont Ave. U.S. A 3304 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Maritei Status Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) filed within 72 hours after 1 ☐ Never Married 2 ☑ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Bleck by 3 Widowed 4 Divorced Yaar or Datas. Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic event, the traumatic event, the traumatic event, the tra Elamentery/Secondery (0-12) College (1-4or 5+) Construction Worker Labor (Construction) 6 grade KIA 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Floyd Fitzgerals KOSA Donis 19e. Informent'e Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) George Fitzgreald 3304 MR. 21213 lifmont Ba(60. 20b. Plece of Disposition (Neme of cematery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 2/15/200 Lansel. 4 ☐ Donelion 5 ☐ Other (Specify) MT. 2101 Cenetary 21. Signature of Funarel Service Licenses 22. Name end Address of Fecility Home Betts Funeral Balto. loman Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, or heart feilure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner physician end s the burial-transit The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Box 68760. Athen schute Physician/Medical Due to (or es e consequence of) P.O. I Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert II. 23b. Did tobacco use contribute to the cause of death? Corebral Vasala signed b Records, ģ 24b. Were eutopsy findings availeble prior to complation of cause of deeth? Completed 24e. Wes en eutopsy page 2 should Osperational Pneumini 1 ☐ Yes 2 No 1 ☐ Yes > No this certificate Division of Vital To the Mospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, to 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Deeth 28a. Deta of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - Al home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as stated.
2 Medical Examinar: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated. edical 29e. Certifier 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

31. Dete filed (Month, Dey, Year) FEB 1 5 2000

30. Name end eddress of person who completed cause of death (Itam 23e) (Type, Print)

32. Reginter's Signeture

M

Howard HBon DMA 9618 Below Road Buttime Md 21236

019793

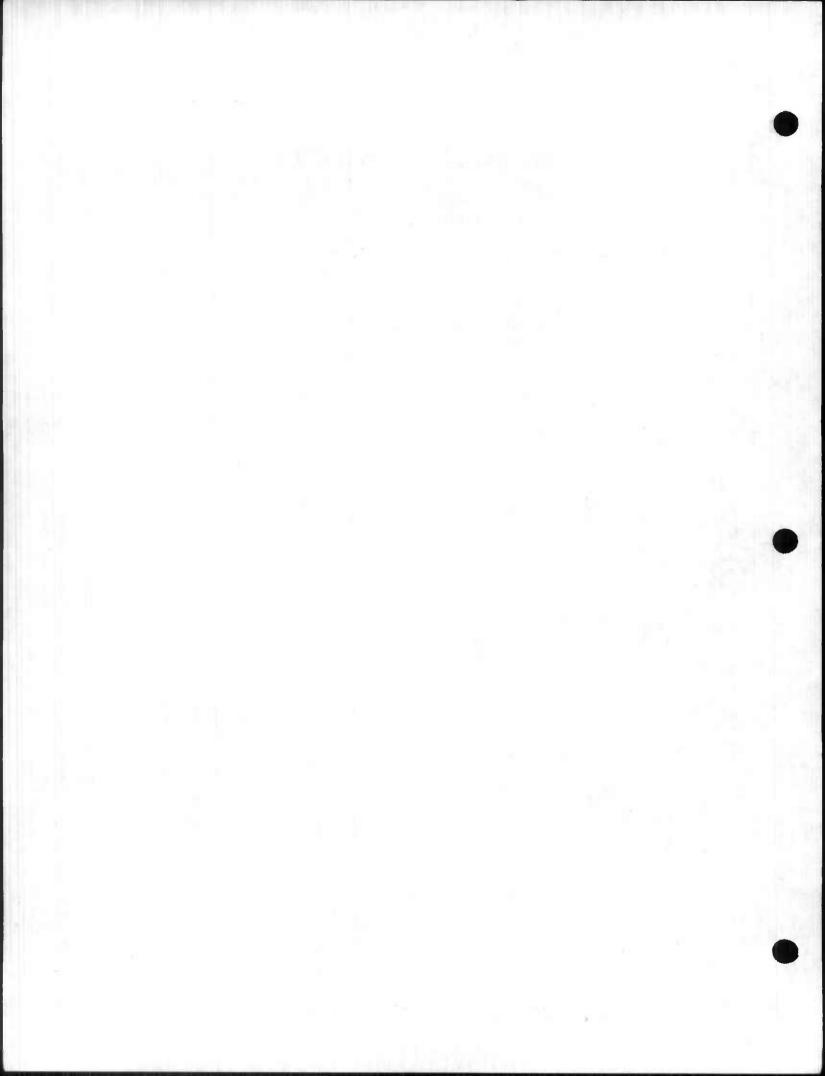
2/14/2000

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State of Maryland / Department of Health and Mental Hygiene 00 01, 500

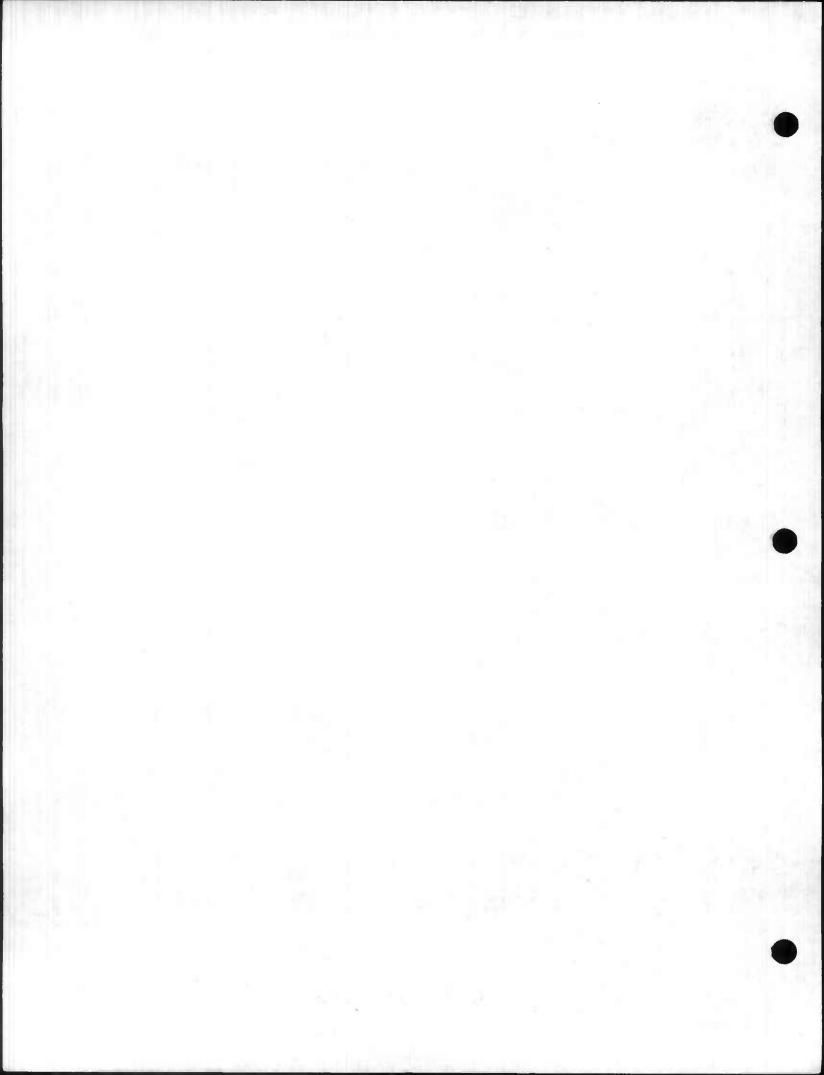
				ertifica	te of l	Death		Reg. No.	JU	4099		
Physician	Decedent's Neme (First, Middle, La MTRTAM	st)		FRI	ED		2. Date of Des Month FEB	12 ^{Day} 200	Year	3. Tima of Death 7:10AM		
/Medical Examiner	4a Facility Name (If not institution, giv SINAI HOSPITAL			LIXI		b. City, Town, or I	ocation of Death		of Death	7:IOAM		
Funeral Director	218-28-9830	ex 7. Age ☐ M 2CXF	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth 9. Birthplace (State or F									
Maryland of show fied at	Usuel Residence of Decedent 10a. Stete 10b. County MD N/A		10c. City, Town o					34	10	d. Inside City Limits 1 1 Yas 2 □ No		
eath with the Mar re 23e or 25e-f a rest be notified erai Director	10e. Street and Number 2903 FALLSTAFF ROA	D APT. 406			Code 1209	ale:	10g. Citizen of What Country? USA					
urs after of Mr, or fren Exercises by Fun	11. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Every Armed Forces? 1 ☐ Yes 2 ☐ Not If Yes, Give A Yeer or Detes:	ver in U,S.	13. Wes Dece If Yes, spe 1 Yes		spanic Origin? (S n, Mexicen, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Rac Blac Specify	e - Americe ck, White, e	ic.		
should be filed within 72 ho of Mental Hygiene. marked other than "nature imatic avent, the Medical To Be Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondary (0-12) 12) (%	Decedent's Usuel Occupation (Give kind of work done during most of v life. DO NOT use retired) MEMAKER		ation furing most of wor f)	working		Kind of Business/Industry WN HOME			
be filed tal Hygid d other avant, B Be Cc	17. Father's Neme (First, Middle, Last)					18. Mother's Ner	eme (First, Middle, Maiden Sumame		10)			
2 should be and Mental la marked o aurmatic ave	HARRY	SCHE	RR			IDA		LEVENS'	TEIN			
pemit. Pages 1 and Department of Health Important: if itam 27 any Injury or other tr once.	BURTON FRIED HU 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specification of Specification of	Removel from Stete]	20b. Plece of C	reposition (Ne crematory or MEMORI	other place AL PA	ARK ss of Fecility	PT. 406 2/13/200 LEVENSO	20c. Location - O RANDAI	City or Tow	m, Stete VN, MD.		
The law requires that the death certificate be assecuted as the last been signed by the attending physician and page 2 should be detached for use as the burial-fransit and an analysis and a completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	e. atheroscitrotic cardiovascular clisase 20 year Due to (or es a consequence of): Due to (or es e consequence of):										
at the death certificate be d by the attending physicis lettched for use as the bu Physician/Medical	resulting in death) Last	d	ue to (or es e cor	isequence or)								
requires that the death cer been signed by the attendin should be deteched for use leted by Physiciary	Pert II. Other algniftcant conditions of		not resulting In the	ne underlying	ceuse giv	en in Pert I.	23b. Dtd 1	1		the cause of death?		
The law require page 2 should be Completed to					_			en autopsy med?	com	re autopsy tindings llable prior to apletion of cause seth?		
	25.111						101		1 🗆	Yes 2 No		
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Property of	27. Menner of Deeth 1 Neturel 5 Panding investigation	28e. Dete of Injury (Month, Day	28b. Tin	28b. Time of 28c. Injury al 28d. Desc					scribe how injury occurred			
	3 Suicide 6 Could not b determined	building, etc.	(Specify)				City or Tox					
To the Hospital or within 24 hours aft To the Funeral Dir completely filled in Medical Ceri	29e. Certifier 12 Certifying Ph (Check only one) 2 Medical Exam	yalctan: To the best of niner: On the basis of e end menner stete	xaminetion and/	eeth occurred or investigation	et the tin	ne, date end plece pinion, deeth occu	rred at the time,	dete and place,	anner as sta and dua to	the cause(s)		
To the comp	29th Sporther and title of certifier	Sof	1		e number +543	2 1	29d. Dete signed (Month, Day, Year) February 12, 2000					
6	30. Neme end address of person who TAWARA SOUBLE	completed cause of dec	oth (Item 23a) (Ty	rpe, Print)	१५८ :	SUIT 40	o Owina	sp Mills	, mo	21117		
State	31. Date filed (Month, Day, Year) FFR 1 5 2	100 32. Registrer			par							

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nysician Medical xaminer	Decedent's Name (First, Middle, Last) JOSEPH				2. Date of Deeth		2 Time of Death		
xaminer			FEIT		3. Time of Death OO 5:00 AM				
neral	4a Facility Name (If not institution, give street end number) MILFORD MANOR NURSING HOME			4b. City, Town, or Lo BALTIMORE	cation of Death	4c. County of BALTIM			
ector	052-14-6284 11XM 2□F 8	rs. last birthday) 66 Yrs.	If Under 1 Yaer Months Deys	Hours Min.	8. Data of Birth (Month, Dey, 1) MAY 22,		Birthplaca (State or Foreign Country) N.Y.		
4	Usual Residence of Decedent 10a. Stela 10b. County 10c.	City, Town or Loc	calion				10d. Insida City Limits		
eath with the Marylar to 23e or 28e-f show must be notified at eral Director	MD BALTIMORE	OWIN	GS MILL	S	1 □ Yes 2 v				
	10e. Streel and Number 26 DEERLODGE COURT #C		10f. Zip Code	21117	10	at Country?			
by Funeral	11. Marilal Status 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yas, Give Yaer or Deles:		Vas Decedent of I Yes, specify Cub	Hispenic Origin? (Speen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Amarican Indian, White, etc. WHITE		
Completed	15. Decedent's Education (Specify only highest grade completed) Elemantery/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give I life. D	ent's Usuel Occu kind of work done O NOT use retire	pation during most of working)	ing	16b. Kind of Business/Industry			
	12 17. Father's Name (First, Middle, Last)	OWNER/	OPERATOR	18. Mother's Neme		ROCERY S	STORE		
To Be	ABRAHAM	FEIT		ANN	(1 1101, 1110010, 111		ANNENBAUM		
	19e. Informent's Neme/Reletionship (Type, Print) CELIA FEIT / WIFE	The second second		ROAD #416					
	20a. Method of Disposition 20th	b. Plece of Dispos					ty or Town, Slele		
	1 ☐ Brial 2 ☐ Cremation 3 ☐ Removel from Stele 4 ☐ Donallon 5 ☐ Other (Specify)			CEMETERY 2	2/13/00	REISTER	STOWN, MD		
	21. Signature of Figure 1 Social Service Lie 1 Social Service Lie 1 Social Service Service Social Service Service Social Service S								
	23a. Pert1. Enter the disease, or complications that caused the dishock, or four failure. List only one cause on each line.						Approximate Interval Between Onset and Deeth		
Je.	Immediate Cause (Finel disease or condition resulting in death) Due to	enine o (or es a consequ	21 10 M uerice of):	q			3 years		
i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarfying Ceuse (Diseasa or injury	(or es e consequence of):							
Medicai		Due lo (or es e consequenca ol):							
iclar	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause of	ven in Part I	23h Did toh	acco use contri	bute to the cause of death?		
by Physician/M		ctive	0 4	4 00	1□ Ye		□ Probably 4 🗇 nknown		
Completed				J	24a. Wes en perform		24b. Were autopsy findings evaileble prior to completton of cause of death?		
					1 🗆 Yes	s 2 No	1 ☐ Yes 2 ☐ No		
o Be	25. Was case referred to medical axaminer? 1 Yes 2 No Hospitel: 1 Inpatient 2	26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
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Cermic	3 Suicide 6 Could not be determined 28e. Pleca of Injury - A building, etc. (Spe	I home, ferm, stre ecity)	el, fectory, office		28f. Location (Stre City or Town,		or Rurel Route Number,		
edicai	29a. Cartifier Tertifying Physician: To the best of my k (Check only one) Medical Examiner: On the basis of exam end menner steted.	knowledge, deelh inelion and/or inv	occurred et lhe ti estigelion, in my	ime, dele and pieca, opinion, deeth occurr	end due to the cer ed at the tima, da	use(s) and menn le and place, and	er as slaled. d dua lo lhe cause(s)		
M	29b. Signature and little of certifier		29c. Lican	se number 27034	f 29	Date signed (Month, Dey, Year)		
	30. Name and address of person who completed cause of deeth (I	10 -	Print)	ort Road	D. 11.	0.0-	1021122		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** GRUEBL GEORGE 23:10 10 2000 ebruary /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital | Unit 14 Hrs | Hunder 24 Hrs | Min. Hopkins Baltimore N/A Johns 8. Date of Birth (Month, Dey, 11/28/ 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 69 219-28-8779 1930 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or itema 23a or 28a-f show the Wedical Examiner must be notified at Baltimore 1 Yas 2 No N/A Maryland Director 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code 21231 1907 Bank Street United States of America Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 1951–54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours aftar 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Newspaper Machine Operator 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Pages 1 and 2 should be 1 nant of Health and Mental I int: if Item 27 is marked of Catherine Gruebl Rychwalski Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any Injury or other trau Leona Gruebl/ Spouse 1907 Bank Street Baltimore, Maryland 21231 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 ☐ Removal from State 02/14 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Maryland Oak Lawn Cemetery 22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore Maryland 21231 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finat STROKE days disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificata be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Due to (or as a consequence of) P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 No 1 ☐ Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Netural 5 Pending investigation after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 Wall FEBRUARY 10, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walker-Ford, 110 Tower Building, Johns Hopkins Hospital, Baltimore, MD 21205 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 5 2000

DHMH 16 Rev 6/95

Registrar

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FOR LOW MANAGERS

Piease Type or Print in Biack indelible ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Paul Felix Grue Feb. 12 2000 1:10 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months Days Hours Yrs. Director 213-05-2717 April 21 1918 Maryland Usual Residence of Decedent death with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow ra 23e or 28e-f shortment at Director 1 ☐ Yes 2 No MD **Baltimore** Timonium 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Glenamoy Rd., **Unit 101** 21093 Funeral USA Herra 2 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ò 1 Yes 2√ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Designer 12 Clothing n/a 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mentel Hant of Hem 27 is marked oth lary or other treumstic even Be Felix Grue Anna Mancini 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addresa (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Ellen Grue/wife 3 Glenamoy Rd., Timonium, MD 21093 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/15/00 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Stete ation 5 Office/(Specify) Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility mp a Lemmon Funeral Home 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Timonium, MD 21093 Approximete Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last a consequence of) menna Physician/Medical the Due to (or as a consequence of): 980 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No Rrobably 4 Unknown Š 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? page 2 should Completed completion of cause of death? certificate funeral director, Be 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Denner (Specify) edical Certification: To 1 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 2 Accident Attending 5 Pending 1 Yes 2 No deeth. investigation after deetl Director: 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide ò 24 hours a Funerel D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 9 29d. Date signed (Month, Day, Year) 29b. Signatury 29c. License number

State Registrar

21215-0020

Baltimore, Maryland

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Division of Vital

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32. Registrar's Signature

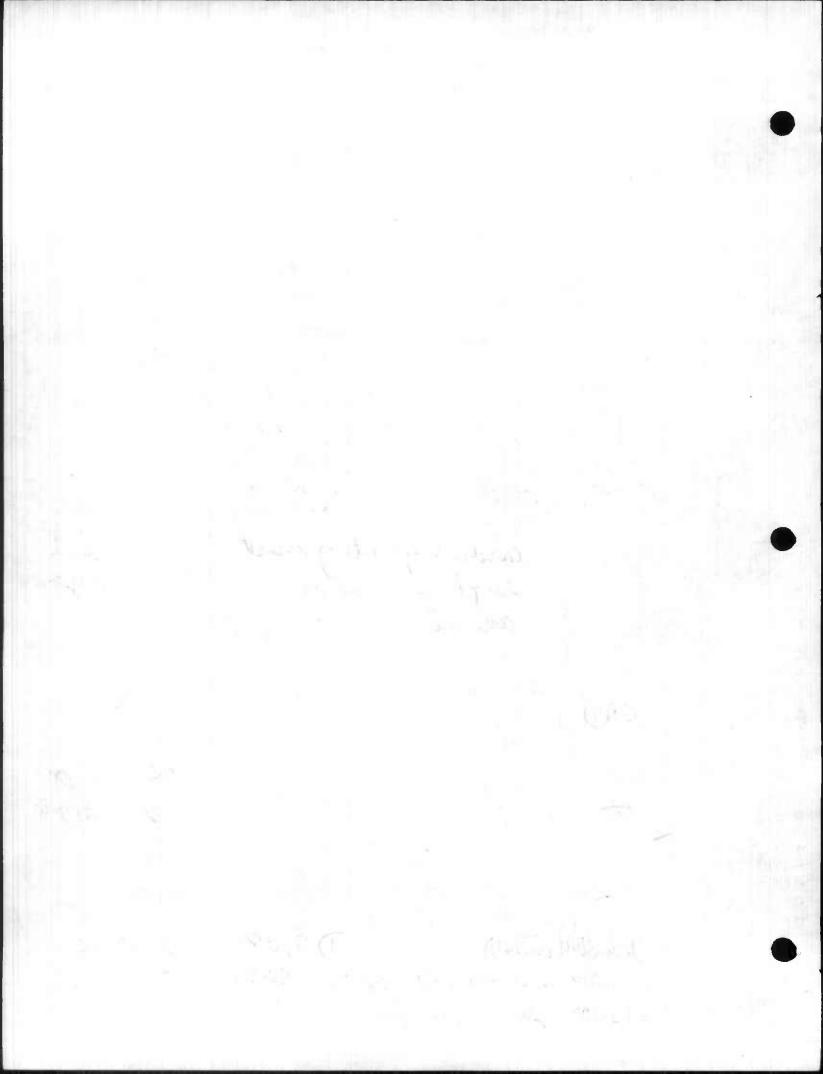
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAMS

RODNEY

31. Date filed (Month, Dey, Year)

FEB 1 5 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8 2000 Gordon Benjamin /Medical 1:00pm 4a Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Forest Nursing Home Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1X) M 2DF Yrs. Director 255-22-8980 Usual Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s 4 show any Injury or other traumatic event, the Healts I can also married any once. 1 Yes 2 No Director MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 12. Wes Decedent Ever in U.S. Armed Forces? 8334 Scott Level 21208

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) U.S.A. 14. Race - American Indian, Black, Whita, etc. Mas 2 No fi Yes, Giva Year or Datas: Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dentist Self Employed 12th grade 12yrs 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 David A. Gordon Liggie Burnett 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

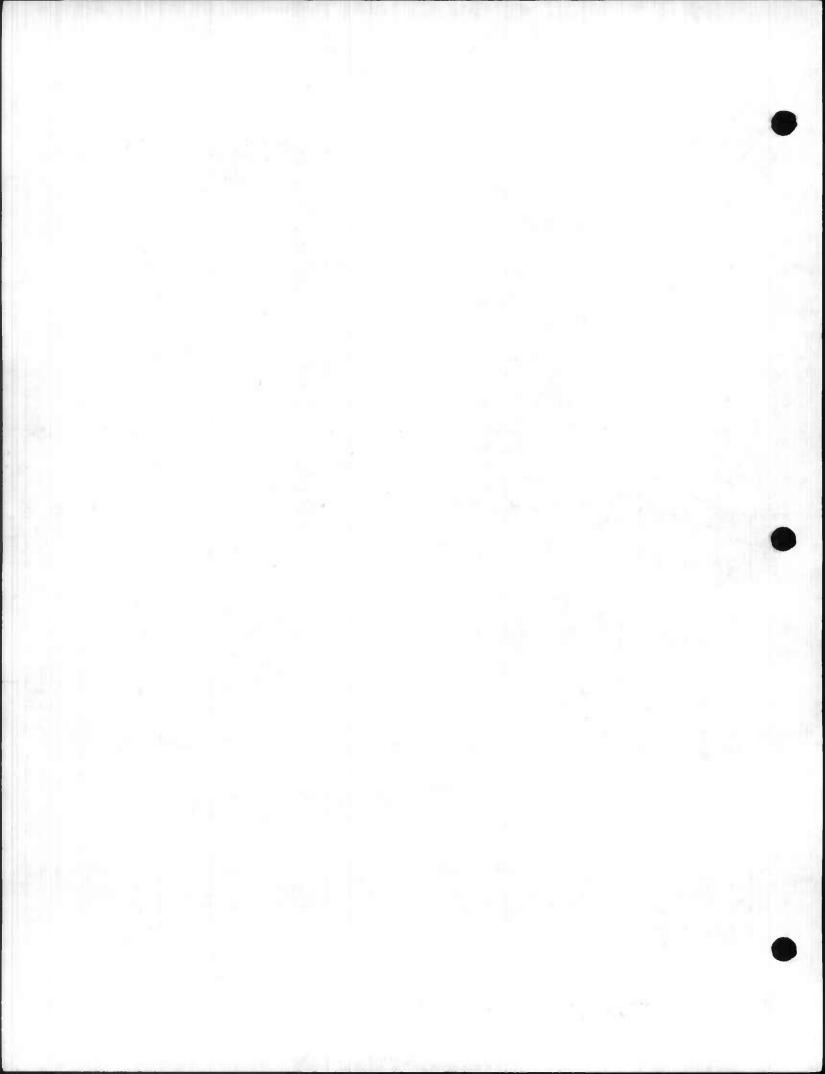
Pikesville, Md 21208

Data 20c. Location - City or Town, Stata Benita Turner-Daughter 20a. Mathod of Disposition 1 Buriat 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 2/19/2000 Sanderville, G.A. Gordon Family Cem. 21. Signeture of Funeral Service Licenses 22. Nama and Address of Facility March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death **Physician** PNEUMONITIS /Medical Immediate Cause (Final disease or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner sician and burial-transit Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or Injury that infliated events rasulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes /2 No 1 Yes 2 No of Vital or Attanding Physician: 25. Was case referred to medicat examiner? edicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division M Natural 5 Panding investigation r death. 1 Yes 2 No 2 Accidant 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital 29a, Certifier If Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signerure and title of cartifier 29c. License number 29d. Data signed/(Month, Day, Year) 2000 weller 30. Nama and addrass of person willo completed causa of death (Item 23a) (Type, Print) AKHANI, JASNEEM 7220 31. Data filed (Month, Day, Year) FEB 1 5 2000

Registrar **DHMH 16 Rev 6/95**

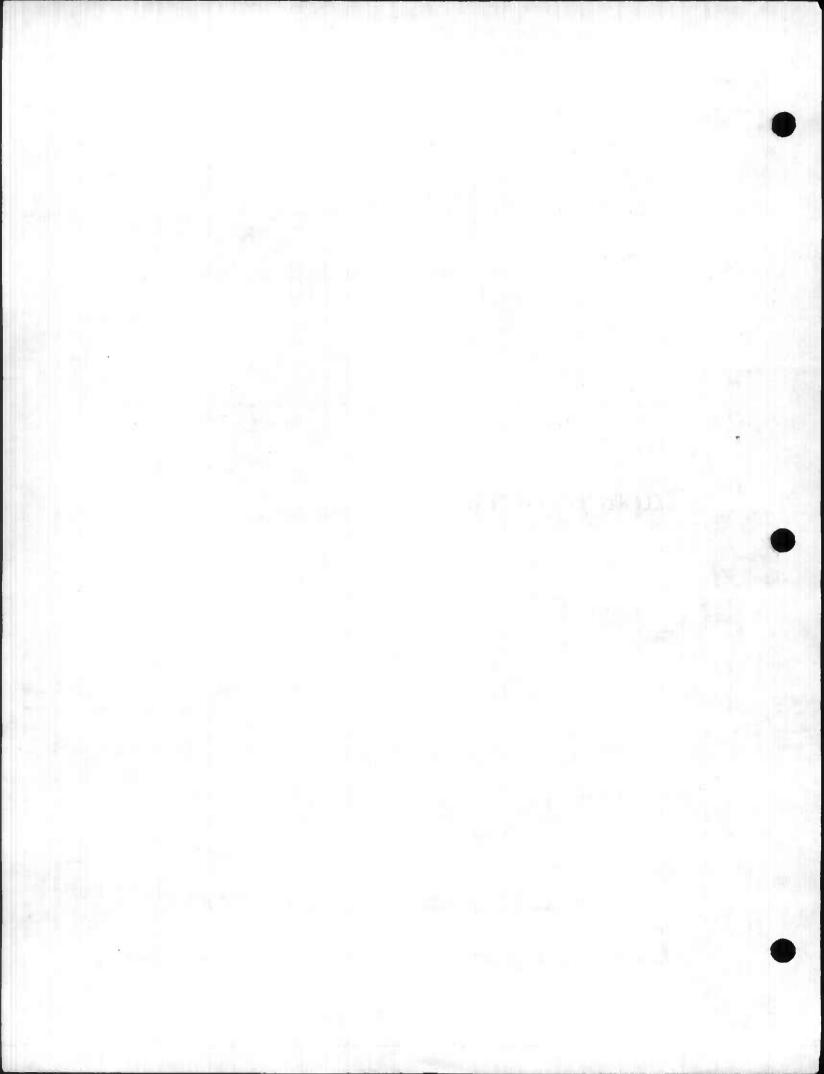
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€. Registrar's Signatura



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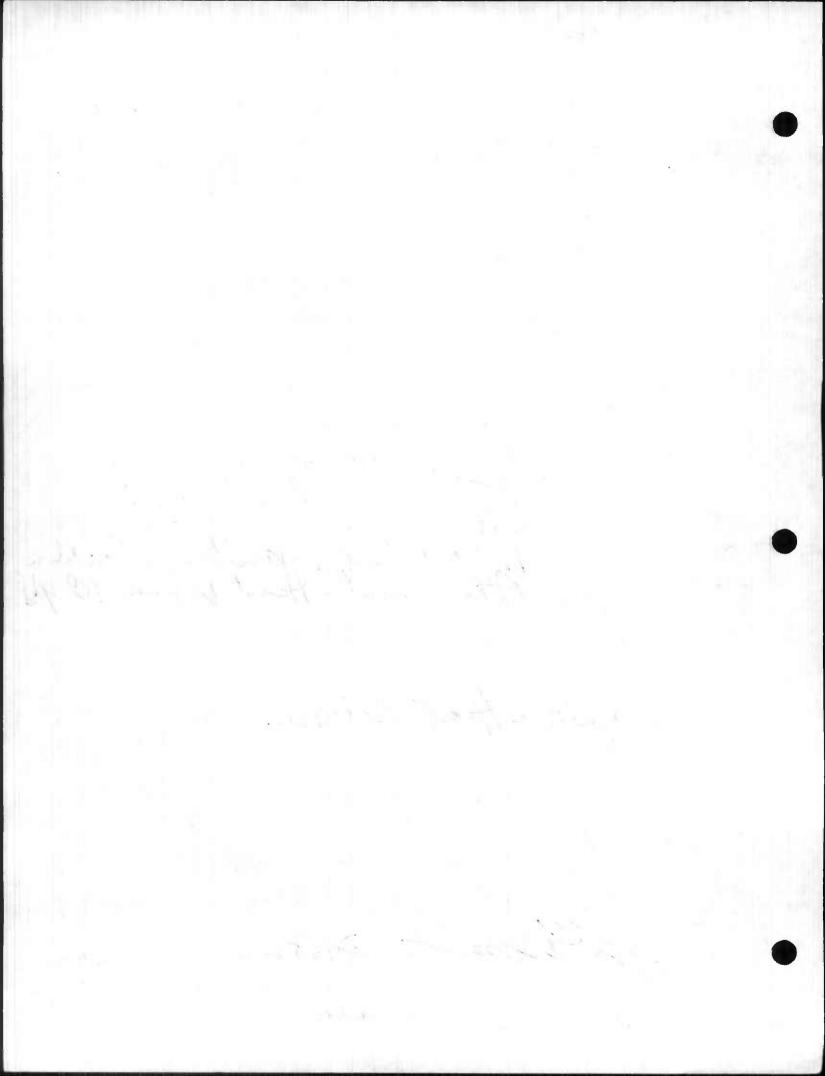
AMEND ITE	State of Maryland / Department of Health and M EM: #5 PER G784 6-15-00 WR. <i>Certificate of Death</i>	fental Hygiene Reg. No.	04704							
Physician /Medical		2. Date of Death Month Day Year February 9 2000 12:30 Pr								
Examiner Funeral Director	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo Franklin Sauare Hospital Center Roseda 5. Social Security Number 216-03-9986 1 M 27F 90 Yrs. 4b. City, Town, or Lo Roseda 4b. City, Town, or Lo Roseda 4c. City, Town, or Lo Roseda 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	ocation of Death 4c. County								
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the Mary 28a-f sh notified	Maryland Baltimore Coun	ty	1□ Yes 2□ No							
€ 5 M D	10e. Street and Number 10f. Zip Code 21206	10g. Citizen of What Country? USA								
020 us after death v sir, or Nema 23a Examinar maint by Funeral	11. Mentel Stetus 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Merried 1 Yes 2 No		e - American Indian, k, Whita, etc. White							
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and the figure of other event.	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maiden Sumam Reichert	θ)							
laryla 2 should and Mee is marks surrette TO	19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rura		State, Zip Code)							
C T W L	Albert J. Gebhardt 523 Elmwood Avenue									
altimore, mit. Pages 1 ar partment of Nee portest; it leen. y Injury or othe £8.	20e. Method of Disposition 1		City or Town, Stata							
Balli Permit Depart Import any ink	21. Signature of Funeral Service Licensee 22. Name end Address of Facility Lassahn Funeral Home									
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/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) a. Myocardial Interction Due to (or as a consequence of): b. Metastatic Breast Cance		2 Days							
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death death death of for u	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i.	23b. Did tobecco use cor	itribute to the cause of death?							
requires that the death certific requires that the death certific wen signed by the attending p hould be detached for use as			3 Probably 4 Unknown							
2 2 5 V		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?							
= F & & O		1□ Yes 2☑No	1 Yes 2 No							
Of Vital I Physician: The This certificate real director, page TO Be Co	Hospital: Hospital: 20 ED/Outputiest 20 DOA Other: 40 Numing Ho	h (Check only one) ome 5 ☐ Residence 6 ☐ Oth	or (Casaib.)							
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DIVI To the Hospital or At within 24 hours affect To the Funeral Direct completely filled in by Medical Certifi	29e. Certifier 1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, (Check only 2) Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred.									
To the Hospital within 24 hours of To the Funeral completely filled	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number		1 (Month, Day, Year)							
	Stuart ackerman D.O. RD 198796	2/9/	00							
15	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart Ackerman m.p. 9000 Franklin Square 31. Date filed (Month, Day, Year) 32. Registrer: Signature	Drive Baltin	nore, MD 21237							
State Registrar	FEB 1 4 2000 > Beneva B. Sparks									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 4 7 0 5

					Ce	rtificate d	or Dea	UI .		Reg. No.			
	dent'a Neme (First,	Middle, La	st)						2. Date of De	ath	Veer	3. Time of Death	
HOWARD GL:							LAZER FEBRUARY 11, 2000					9:00 AM	
A	ity Name (If not ins	titution, giv	e street and nu	m <i>ber)</i>			4b. City	, Town, or	Location of Deet	h 4c. Coun	y of Death	1	
		DURT	ROAD #5										
21	5. Social Security Number 6. Sex 1218-32-1970								(Month, De	th 1y, Year) 5, 1910	9. Birthplace (State or Foreign Country) VA		
-				10c City	/ Town or L	ocation		_				10d. Inside City Limits	
	MD BALTIMORE BALTIMORE 10a. Street and Number 10f. Zip Code								1 ☐ Yes 2 🕅 No				
10. Street and Number 4001 OLD COURT ROAD #504 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wes Decedent of Hisp.						1208		10g. Citizen of What Country? U.S.A.					
3 🔯	Never Married 2		Armed Fo	orces? 2 X No ve		If Yes, specify (Cuban, Mex	dcan, Puer	Specify Yes or Norto Rican, etc.)	BI	ack, White		
	15. De	cedent's E	ducetion		16a. Dece	dent's Usuel Oo	cupetion	most of wo	ndkina	16b. Kind of	Business/Ir	ndustry	
Elem	Elementary/Secondery (0-12) College (1-4or 5+)			1-4or 5+)								ORATION	
17. Fath	er's Name (First, M	liddle, Last)				18. M	other's Ne	me (First, Middle				
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Decedent's Education (Give kind of work done during most of work	4a Facility Name (If not institution, give street and number) 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deet 4b. City, Town, or Location of Deet 4b. City, Town, or Location of Deet 5. Social Security Number 6. Sex 218-32-1970 120 M 2 F 7. Age (In yrs. last birthday) 4b. City, Town or Location of Deet 4b. City, Town, or Location of Deet 4b. City, Town or Location of Deet 4b. City, Town, or Location of Deet 4b. City, Town, or Location of Deet 4b. City, Town or Location of Deet 4b. City, Town or Location of Deet 4b. City, Town or Location or Place of Disparcion or State of BALTIMORE 10c. City, Town or Location 8b. City, Town or Location 10c. City, Town or Location 11c. City, Town or Location 11d. Marital Status 11d. Marital Status 11d. Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, Specify Cuban, Mexican, Puerio Rican, etc.) 11d. Marital Status 11d. 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Age (In yrs. last birthday) 180 M 2 F 7. Age (In yrs. last birthday) 180 Months Deys Hours Min Deyc Hours Min Deyc. 25, 1910 180 BALTIMORE 180 LTIMORE 180	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Everett 10:01 AM 2 14 2000 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Long View Nursing Home Inc Carroll County Manchester Hours Min. 8. Dete of Birth (Month, Day, Year) Feb 8 1917 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Deys 10XM 2□ F Months Country) NorthCarolina 213-07-7232 83 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Carrol1 Manchester 1 ☐ Yes 21 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3332 Main Street 21102 USA 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Stetus 14. Race - American Indian, Bieck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: White 3 NWidowed 4 □ Divorced Yeer or Detes: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) College (1-4or 5+) Foreman 12th Beth Steel 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Everett Hines Lillian Coleman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Everett R.Hines / son 6500 Wolf Gang School Road Glen Rock PA 17327 20b. Piece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Holly Hill Cemetery 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 2/18/2000 Baltimore Md. 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of ations that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, Approximete Interval Between Onset end Deeth Immediate Cause (Fine) disease or condition resulting in deeth) Due to (or as e consequence of) Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): thet initieted events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Ch. 24b. Were eutopsy findings aveilable prior to completion of cause 24e. Wes en eutopsy of death? 1 Yes 2 No 1 Yes 2 No 25. Wes cese referred to medice exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Physiclan /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

2

10e. State

MD

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "n any Injury or other traumatic event

the Maryland show

Baltimore, Maryland 21215-0020

detached page 2

be executed physician and s the burial-trans P.O. Box 68760. The law requires that the death certificate attending p 2 signed t Division of Vital Records, has l or Attending Physician: after death. Director: After this certifica funeral 2 ni bellih To the Funeral Completely filled

State Registrar

Examiner Physician/Medical þ Completed Be 2 Certification:

3 ☐ Sulcide 4 Homicide 29a. Certifier

* Naturel

2 Accident

29b. Signature and fi

investigetion 6 Could not be determined

5 Pending

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

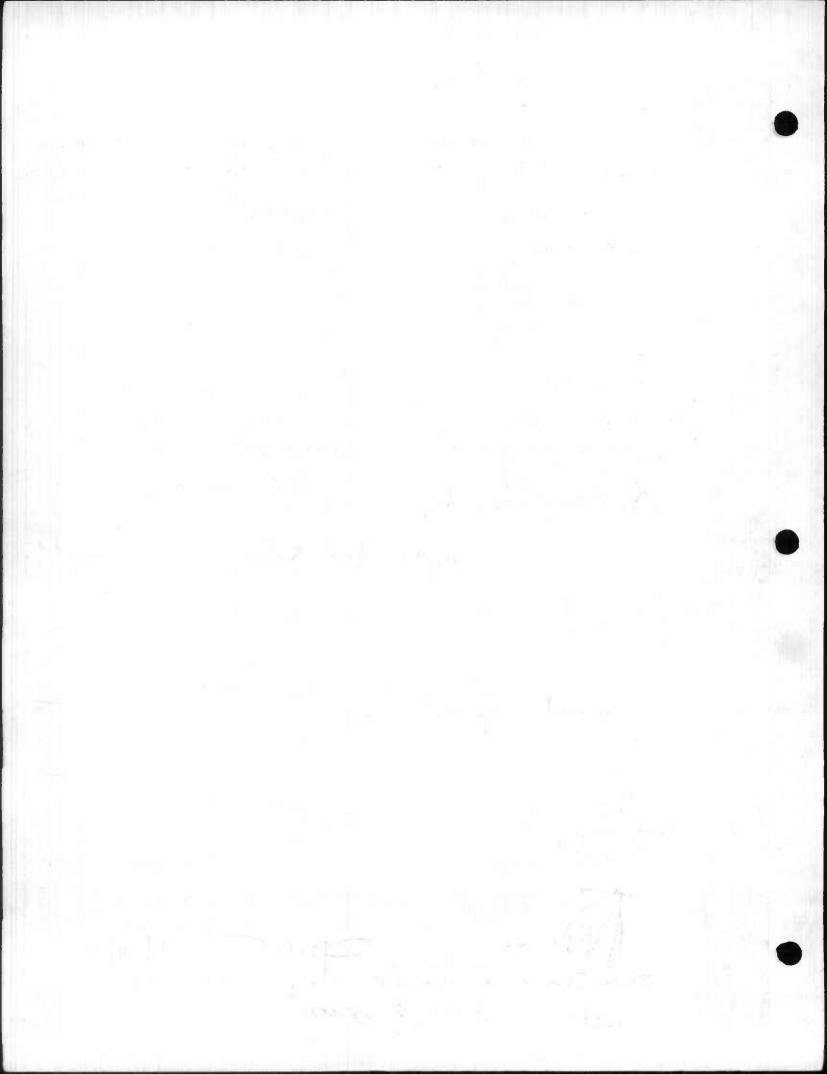
Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

3316

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Steich anser Pike a am 111 S

31. Dete filed (Month, Day, Yeer) FEB 15 32. Registrer's Signeture



P.O. Box 68760 Division of Vital Records,

physician end the buriel-transit that the death certificete be executed 88 USB ed by signe be d certificate or Attending Physician: this After after deeth. Director: Aft Hospital of 24 hours a Funerel D vithin 2.

the Maryland

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death

7 is marked other than "natural", or items 23s or 28a-f show treumstic event, the Medical Examiner must be notified at

iny injury or other

per it Peges 1 and 2 should be filled within 72 hours after in partment of Health and Mental Hygiene.

HORN, Charles L.

31. Date filed (Month, Day, Yaar) FEB 1 5 2000 State Registrar

29b. Signeture and title of certifier

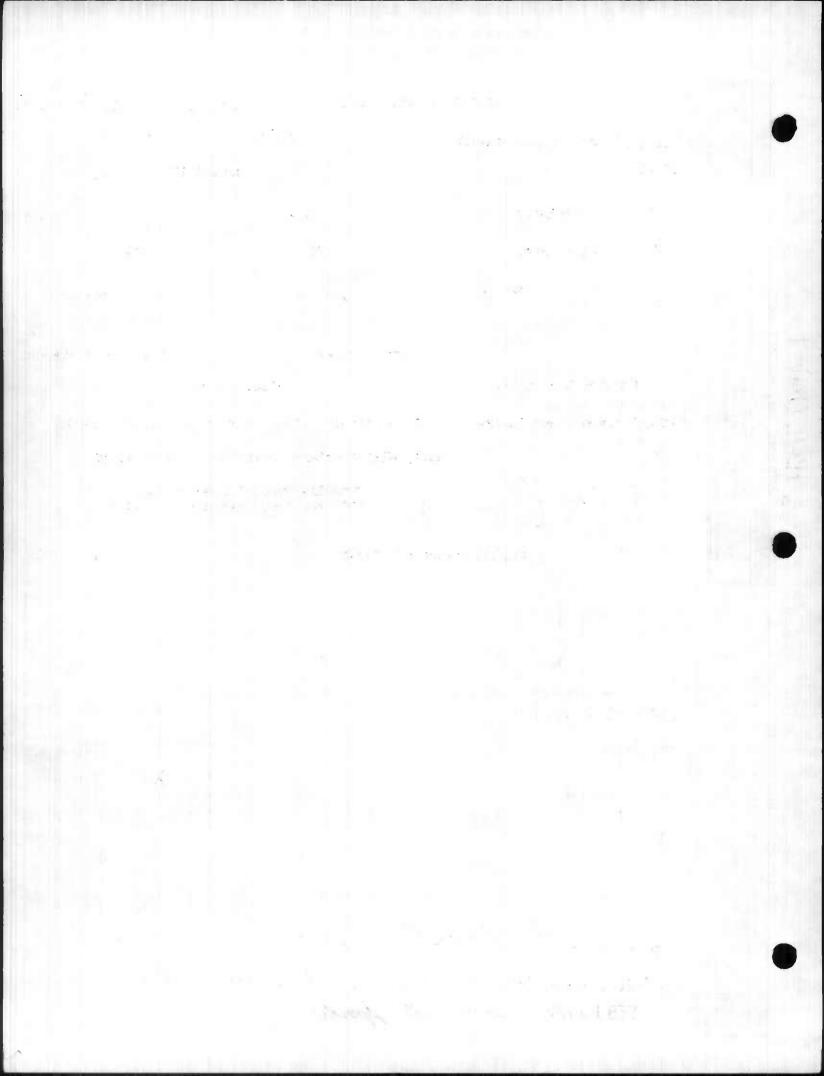
29c. License number D 46179

29d. Date signed (Month, Day, Year) February 11, 2000

30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) Dr. Hossein Babgali

9000 Franklin Square Drive, Baltimore, Maryland

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death #28F PER MD G781 3-3-2000 WR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey . Month **Physician** tebruary 11,2000 2:09AM JAMES HETMANSKT H. /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedala Franklin Square Hospital Baltimore enter H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1₽M 2□F Yrs. 215-01-0037 87 April 29,1912 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inalde City Limits 1 ☐ Yes 2 TNo Director Md. Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3617 Wheel House Road 21220 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Factory 12th Cutter 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Anton Hetmanski 2 Rose Krolczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addresa (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn E. Cline/friend 3617 Wheel House Road Baltimore, Md. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State N Burial 2 ☐ Cremetion 3 ☐ Removal from State Stanislaus Cemetery 2/14/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CONNELLY FUNERAL HOME OF ESSEX 23a. Part1. Enter the disease, or complications that caused the plan point enter the mode of dying, auch as cardiac or respiratory arrest, interval Between Onset and Death Immediate Cause (Final entricular disease or condition resulting in death) Physician/Medical Examiner 1140 cardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Schemic Cardiomyopathy Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 Netural 5 Pending

The law requires that the death certificate be executed physician and s the burial-transit Box 68760. P.O. signed by the a of Vital Records. page 2 t certificate Physician: funeral director. Certification: To this After death. Lafter death Director: filled in by 6 24 hours Hospita

Funeral

Director

288-11

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ls marked

Important: If Item 27 any Injury or other to

Physician /Medical

Examiner

Jame

manskis

1 | Yes 2 | 1100 investigation 2 Accident 6 Could not be 28e. Plece of Injury - At home, term, street, tactory, office building, etc. (Specify) 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a, Certifier

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basts of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and little of certified

Ranged Jeffrey S 29c. License number 29d. Date signed (Month, Day, Year)

H0052365 February 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Squise Suite 321 Baltimure, MD 21236 9101 Franklin 31. Date filed (Month, Day, Year)

State Registrar

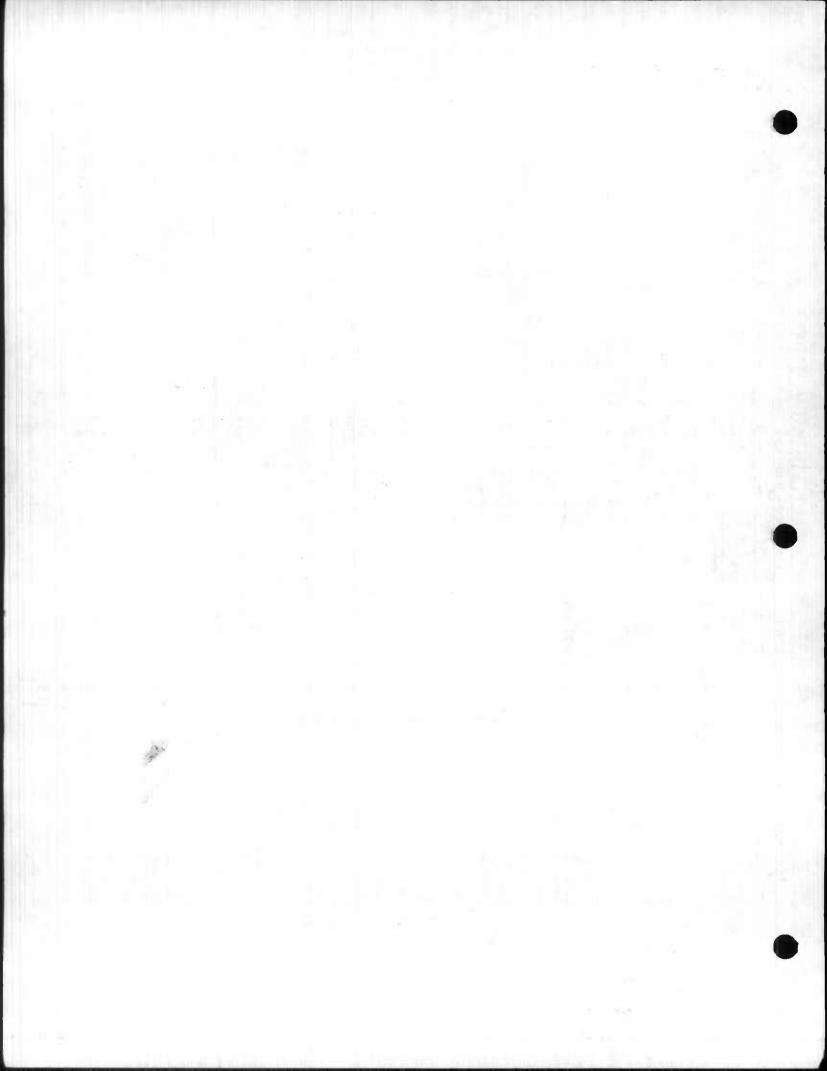
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> 32. Registrer's Signature MAR 03

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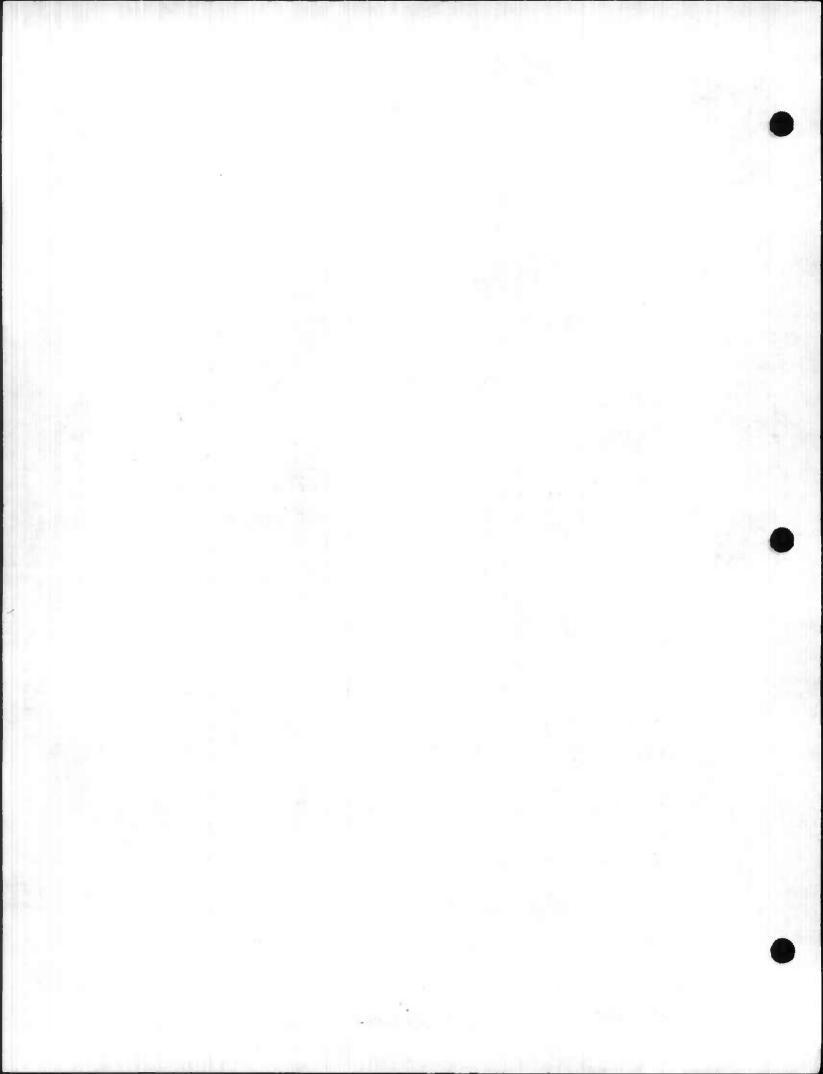


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Year **Physician** FEBRUARY 14,2000 HOFF MAN CHARLOTTE 8:15 AM /Medical 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth 4b. City. Town, or Location of Deeth Examiner CENTER NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 5. Sociei Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthdey) **Funeral** 1□M 2 F 98 Yrs. 076-14-4320 Director Usuei Residenca of Decedent tor 28a-f show be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 7200 Third Avenue 21784 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 6 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: à 3 Widowed 4 □ Divorcad White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Coilege (1-4or 5+) Elementery/Secondery (0-12) Teacher High School 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Charles Frederick Feast Margaret Herbert 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If Item 27 is or other tra-Harry Lee Hoffman, III/son 405 Gun Road Baltimore, MD 21227 20b. Piece of Disposition (Name of cametery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 【Cremetion 3 ☐ Removel from Stete Metro Crematory, Inc. 2/15/00 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of rune al Service Licensee Commund 22. Neme end Address of Fecility
Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death **Physician** /Medical immediate Cause (Finel SEPSIS diseese or condition resulting in deeth) Examiner Completed by Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequenca of): use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? HYROIDISM 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: edical Certification: To Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ☐ ER/Outpetient 3 ☐ DOA s after death.

Il Director: After this ed in by the funeral d After this 27. Menner of Deeth 1 Neturei 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how Injury occurred Division 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital owithin 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 043462 19.5. RAO. M.D FEBRUARY 14,2000 30. Name and address of person who completed cause of death (item 23a) (Type, Print) K.S. RAO. F.O. NANDALLETOWN, MID HOSPITAL CENTER. NORTHWEST 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State FEB 1 5 2000 Registrar

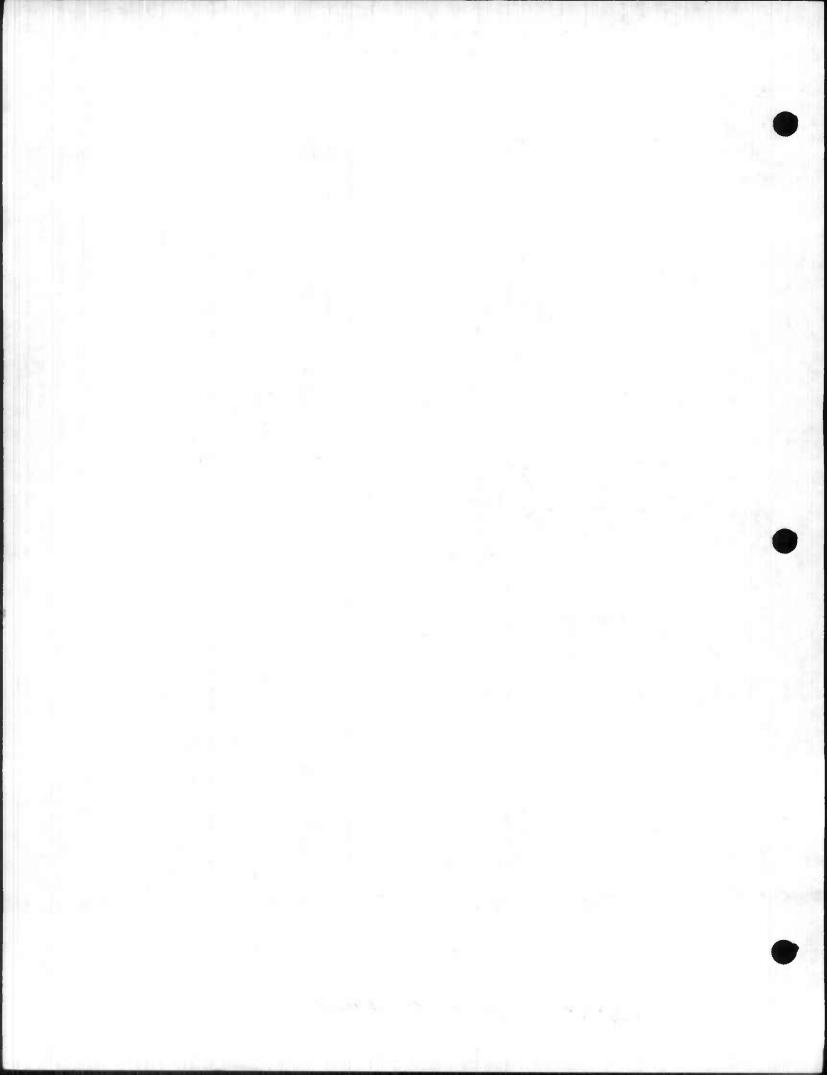
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 1, 7 1 0

			Ce	rtificate of	Death		Re	g. No.			
Dhusisian	1. Decedent's Neme (First, Middle, I					2. Data of Death	Data of Death Month Day Yaar 3. Tima of Death				
Physician /Medical		Hall, Sr.		Febr					uary 07, 2000 6:43am		
Examiner	4a Facility Name (If not institution, g Maryland Gener	· ·			Balt	imo	cation of Death	4c. County	y of Death		
Funeral Director	216-86-2954	Sex 7. Age (In yrs. 39	Ast birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of (Month) North					irth lay, Year) 7-60 9. Birthplaca (Stata or Foreign Country) MD			
2 1	Usual Rasidence of Decedent 10a. Stete 10b. County	10c. City	y, Town or Lo	ocation	_				1	0d. fnside City Limits	
with the Maryland or 25a-f show be notified at Director	MD NA	Ва	ltimo							XXYes 2 No	
1 0 M O		Court		10f. Zip Code 2120	1		10	g. Citizen of US		try?	
DY E		12. Wes Decedent Ever in U, Armed Forces? 1 □ Yes 2 □ No If Yes, Give X Yeer or Detes:		Wes Decedent of If Yes, specify Cu 1 ☐ Yas 2 ☐ No	ban, Mexicar	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	ify Yes or No- ican, etc.) 14. Race - American Indian Black, Whita, etc. Specify: Black			
Z1Z15-00Z0 d within 72 hours at pleno. r than "natural", or the Medical Exam	15. Decedent's (Specify only highest g	Education trade completed)	(Give	dent's Usuel Occu kind of work done DO NOT use retir	a durina mos	t of work	ing	6b. Kind of B	usinass/Inc	lustry	
	Elementery/Secondery (0-12) 10th Grade	College (1-4or 5+) NA	Laborer							rades	
D STEER OR	17. Fathar's Neme (First, Middle, Las						e (First, Middle, M				
2 should and Man is marks summite	Thomas 19e. Informent's Neme/Reletionship	Hall, Sr.	19h Maili	Ophelia Jack							
Baltimore, Mig permit. Papes 1 and 2 Department of Health a Important: If them 27 is any injury or other tras any injury or other tras	Ophelia 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Domittee 5 Other (Spec	□Ramoval from Stete M E	Piece of Disponentery, created a Zic	osition (Neme of metory or other pi On Ceme:	ece) tery rass of Fecili	02+3	Date 2 12-2000 altimor	Lanse, Ma	-city or To down ryla	e, MD nd 21202	
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Contributions be executed with the physician and the pural-transit assets the burlantansit and the pural purple of the purple of	Cause (Disease or Injury thet initiated events resulting in death) Last	c. GZ 6/	feul consecutive as a consecutive d	quence of):							
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at the death of the death of the death of the attend etached for us.	Pert II. Other significant conditions	contributing to death but not rest	ulting in the u	ınderlying ceuse g	iven in Pert	l.	23b. Did to	Dacco use co	ontributa to	the cause of death?	
s that the de gned by the be detached by Physic							1 🗆 Ye	8 2 No	3 ☐ Prol	bably 4 Unknown	
aw requires been so a should pleted							24a. Was er perform	n eutopsy ned?	SV:	ere autopsy findings allable prior to impletion of ceuse death?	
The tarte he page							1□ Ye	s 2/2 No	10	☐ Yes 2☐ No	
Physician: The Physician: The Be Co	25. Was case referred to medical examiner?	Hospitel:			thor:		h (Check only one				
ding Physic h. After this of funeral direction: To	1 Yes 2 No 27. Menper of Death Neturel 5 Pending investiget	28a. Dete of Injury (Month, Dey Year)	28b. Time o Injury	of 28c. Inj	4 LI NI		The second secon	Residence 6 Other (Specify) cribe how injury occurred			
DIVISION of the or attending P as after death. al Director: After the or in by the funers Certification:	3 Suicida 6 Could not determine	ha	9 Ole Disce of Injury. At home form street featons office				28f. Location (Street end Number or Rurel Rout City or Town, State)			al Route Number,	
Hospi 4 hou Funer lishy fill	29a. Certifier (Check only one) Certifying F	Physician: To the best of my known miner: On the basis of examiner end menner steted.	wledge, deet tion end/or in	h occurred at the ivestigation, in my	tima, dete er opinion, des	nd plece, oth occur	end due to the ca	use(s) end m ite end place,	anner as s , and due to	tated. o the ceuse(s)	
To the within 2 To the comple	29b. Signetura and title of certifiar			29c. Lica	nse number		29	d. Date signe	ed (Month,	Dey, Year)	
	/	and MD			893	34	1	2/	7/0	0	
4		lsania, MD N	Maryla	Print) and Gen	eral	Hos	pital 8	321Lir	ıden	Avenue	
State Registrar	31. Date filed (Month, Day, Year) FEB I 5 20	32. Registrer's Signe	sture &	Spork	21.						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year AMMOND HOLSTON FEBRUARY 13 2000 1841 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE VA HOSPITAL 5. Sociel Security Number if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) Deys 1**∑** M 2□ F Months Hours Min 76 Yrs. March 30, 1923 Maryland 217-16-5637 Usuai Residence of Deceden 10a Stete 10h County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 X No Carroll Manchester Maruland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21102 U.S.A. 2799 Bert Fowler Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, 11 Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Married white. 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Gas & Electric Elementery/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Company 8th Grade 18. Mother's Neme (First, Middle, Meiden Surneme) 17 Father's Neme (First, Middle, Last) Essien Thomas Holston Mary 19a, informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Elizabeth Holston (wife) 2799 Bert Fowler Rd., Manchester, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurlal 2 ☐ Cremetion 3 ☐ Removei from State Oak Lawn Cemetery 2/17/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Road, Baltimore, Mayot- Zavace 21236 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Finel MYELOMA ONE MONTH disease or condition resulting in deeth) MULTIPLE Due to (or es e consequence of). Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE 24b. Were eutopsy tindings available prior to completion of ceuse of deeth? 24a. Wes an autopsy HYPERTENSION 1 Yes 200 No 1 Yes 2 No 25. Was case referred to medicel examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28e. Dete of injury (Month, Day Year) 28c. Injury at Work? Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Examiner physicien and s the buriel-transit that the death certificate be axecuted Division of Vital Records. P.O. Box 68760. Physician/Medical signed by the þ Completed certificate has linector, page 2 s The or Attanding Physician: funeral director, Be Certification: To death. after deat Director: 2

Physician

/Medical

Examiner

Funeral

Director

"natural", or itams 23a or 28a-f ahow

Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene.
This If Hear 27 Is marked other than "natural", or Hama 23, mit. If Hear 12 Is marked other than "natural", or Hama 23, mry or other traumatic avent, the Mencial Estations must ny or other traumatic avent, the Mencial Estations must ny or other traumatic avent, the Mencial Estations must not other traumatic avent, the Mencial Estations must not other traumatic avent.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Directo

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with

To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical

Glindrens

29b. Signature and title of certifier

29a. Certifier

ANDRENS

29c. License number P13356

Certifying Physician: To the best of my knowledge, death occurred et the time, dete and piece, end due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner stated. 29d. Dete signed (Month, Dey, Year)

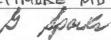
FEBRUARY 13 2000

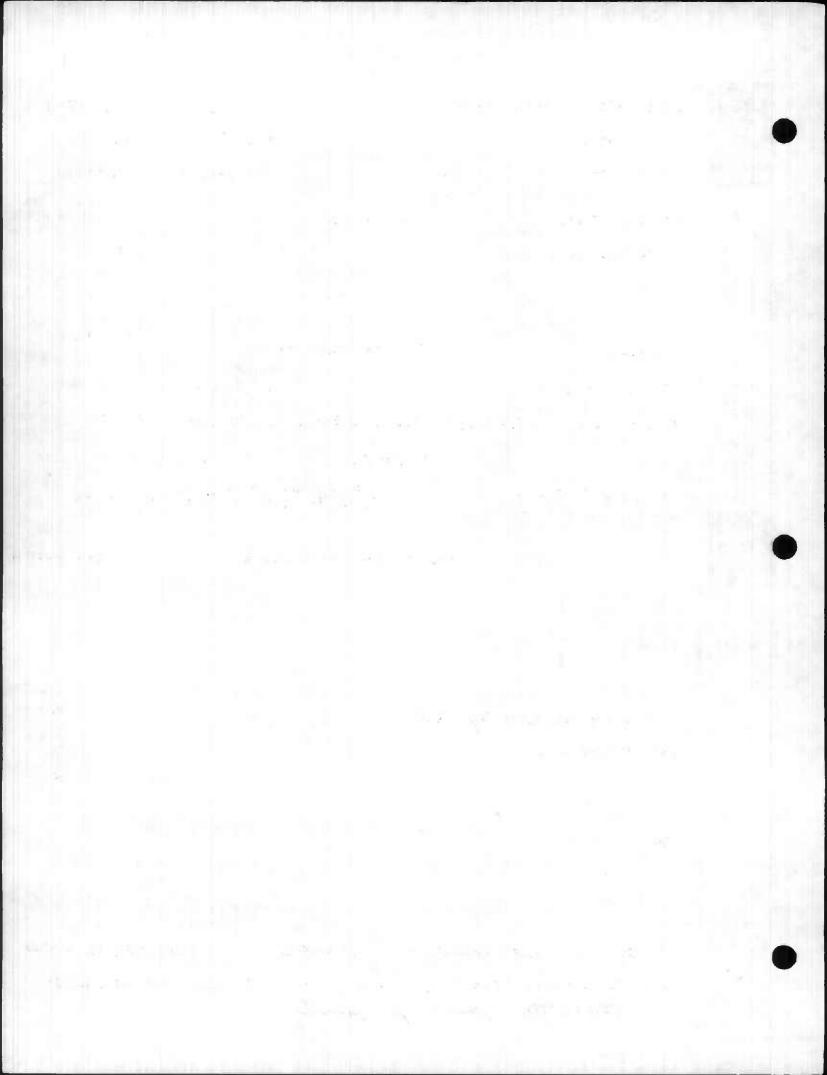
30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

NORTH GREENE STREET BALTIMORE MD 21201 HEATHER ANDROWS

31. Dete filed (Month, Day, Year) FEB 15 2000 State Registrar

32. Registrer's Signature





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G780 2/15/00 yg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Marthetta L. Hickles 07:45 A 02 2000 11 /Medical 4a Facility Name (II not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Mary land Hospital Baltimore City Baltimere If Under 1 Year | If Under 24 Hrs. | 5. Sociel Security Number 213-20-809/ 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2\ F 78 312 20 8097 Usuat Residence of Decedent Director 01/07/1922 Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at Director Maryland Baltimore 17 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 952 W. Franklin Street 21223 Funeral U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Custodian School system .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Item 27 ia marked other to jury or other traumatic event, to Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Burke Hattie Johnson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 952 W. Franklin St., Baltimore, Maryland 21223 Tomicina Murphy / Daughter aitimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method ol Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete Department of Important: If eny injury or page. 4 Donation 5 Dother (Specify) Zion Cemetery 02/17/00 Landsdowne, Maryland 22. Name and Address of Fecility 21. Signeture of Funeral Service Licenses Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Pent1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause project line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final Pulmonary disease or condition resulting in deeth) **Examiner** Examiner secondary to multiple CVAS The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Box 68760, Hypertension Physician/Medical Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Preumonia þ Records, 24a. Was an autopsy performed? Completed 24b. Were autopsy tindings available prior to completion of ceuse 2 No 1 Yes 2N No of Vitai Attanding Physicien: director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No this funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigetion Division 1 Neturel apital or Attanditions after death. death. 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 24 hours a 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one)

M State Registrar **DHMH 16 Ray 6/95**

31. Date Illed (Month, Dey, Year) FEB 1 5 2000

A.M.

29b. Signeture end title of certifier

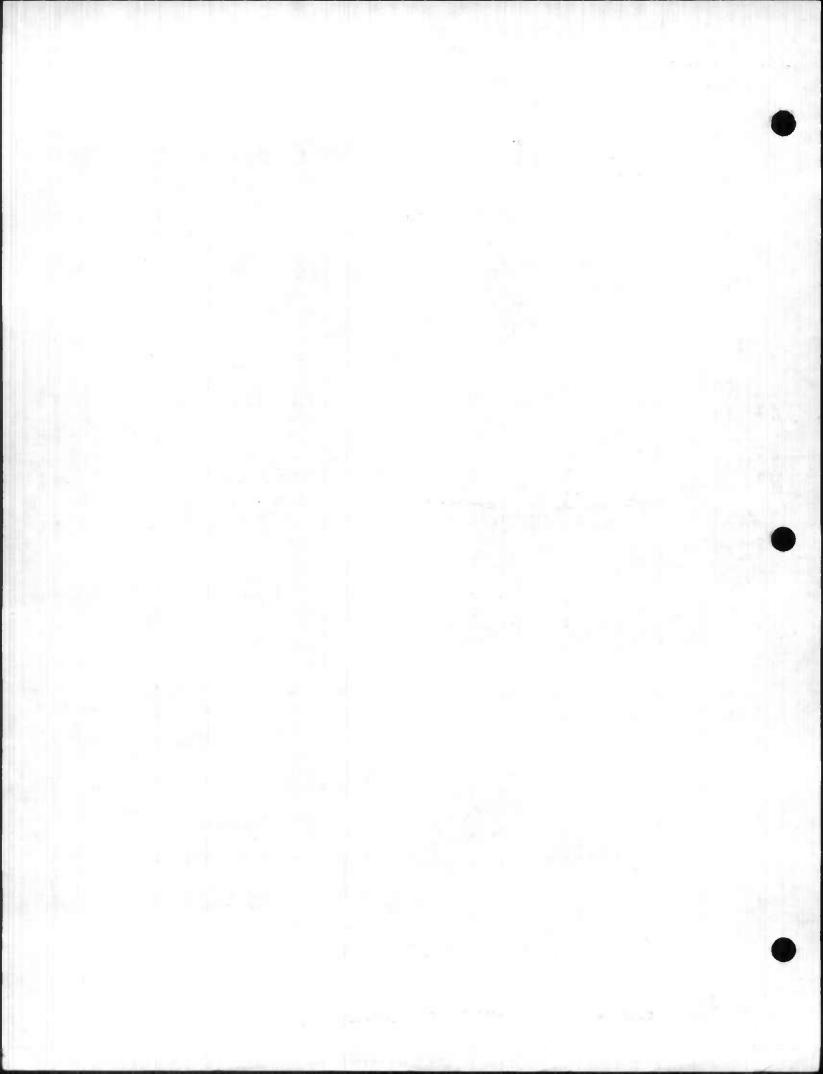
225 Greene Street, Baltimore, MD 21201 32. Registrer's Signeture,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bothwell

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dale of Death 3. Time of Death Month Year **Physician** HUNTLEY LAWRENCE 6-20 PM % 200 s 4c. County of Death Februar /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) **Examiner** BON SECOUR HOSPITAL BALTIMORE H Under 1 Year H Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Dey, Year)
JUNE 28, 1957 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Yes. 715-64-7622 42 Director MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director 288-1 MARYLAND N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 2 2428 BRENTWOOD AVENUE 21218 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 12. Wes Decedani Evar in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after of health and Mental hygiene.
ant: if Nem 27 is marked other than "natural", or Nes
ury or other traumatic avent, me Medical Emontary. 1 ☐ Yas 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: AERO-AMERICAN à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABOR SANTTATION 12TH 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be DILLON HUNTLEY THELMA RUSHING 20 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DILLION AND THELMA HUNTLEY/PARENTS 2428 BRENTWOOD AVE. BALTO, 21218 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If He any Injury or oti 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) GREEN MOUNT CEMETERY FEB. 14, 2000 BATTO, MD. of Funerel Service Licensee 22. Name end Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel Sepul disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of) umouin The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate causa. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760. Acquired Immunode Physician/Medicai Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown þ Records, should be 24b. Wera autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Yes 2 PNo 1 Tyes 2 No certificata Division of Vital Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Affer t PNetural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and mannar steled. 29e. Certifier 29d. Dala signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 47804 ruec

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DHMH 16 Rev 6/95

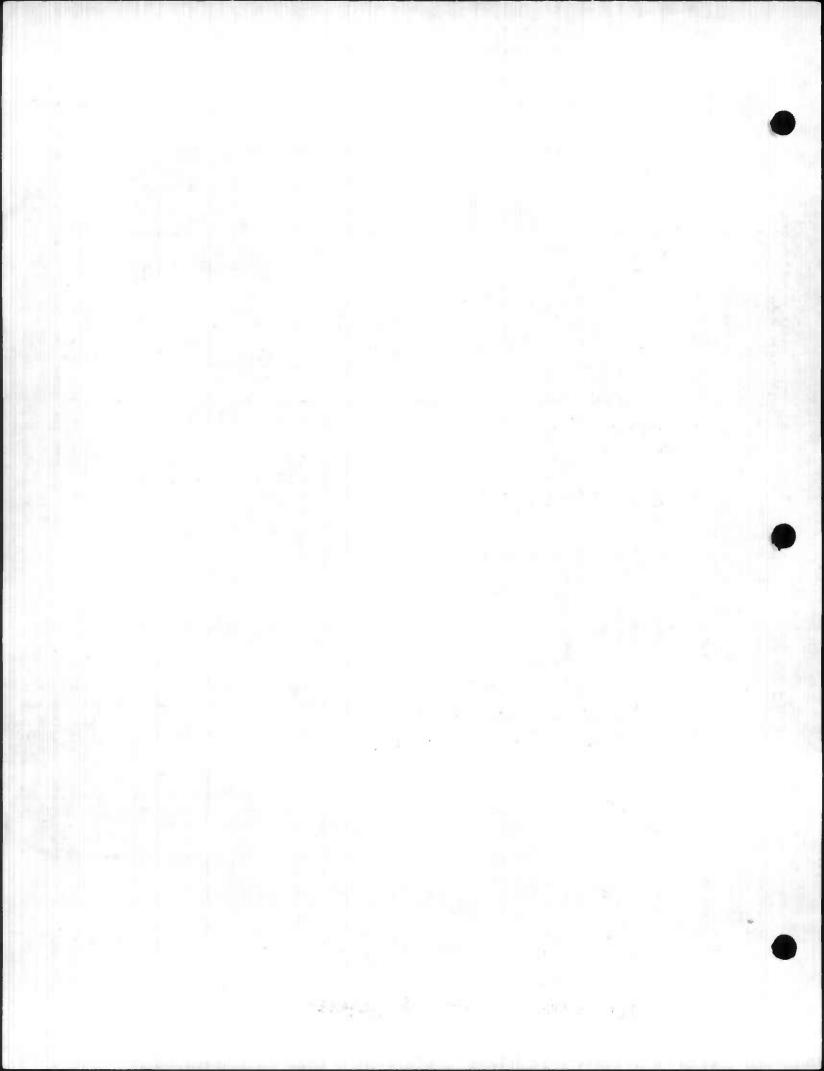
State Registrar 530 N.HILTON ST.BALTO, MD. 21229

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signeture

ANDREW MROWIER MD.

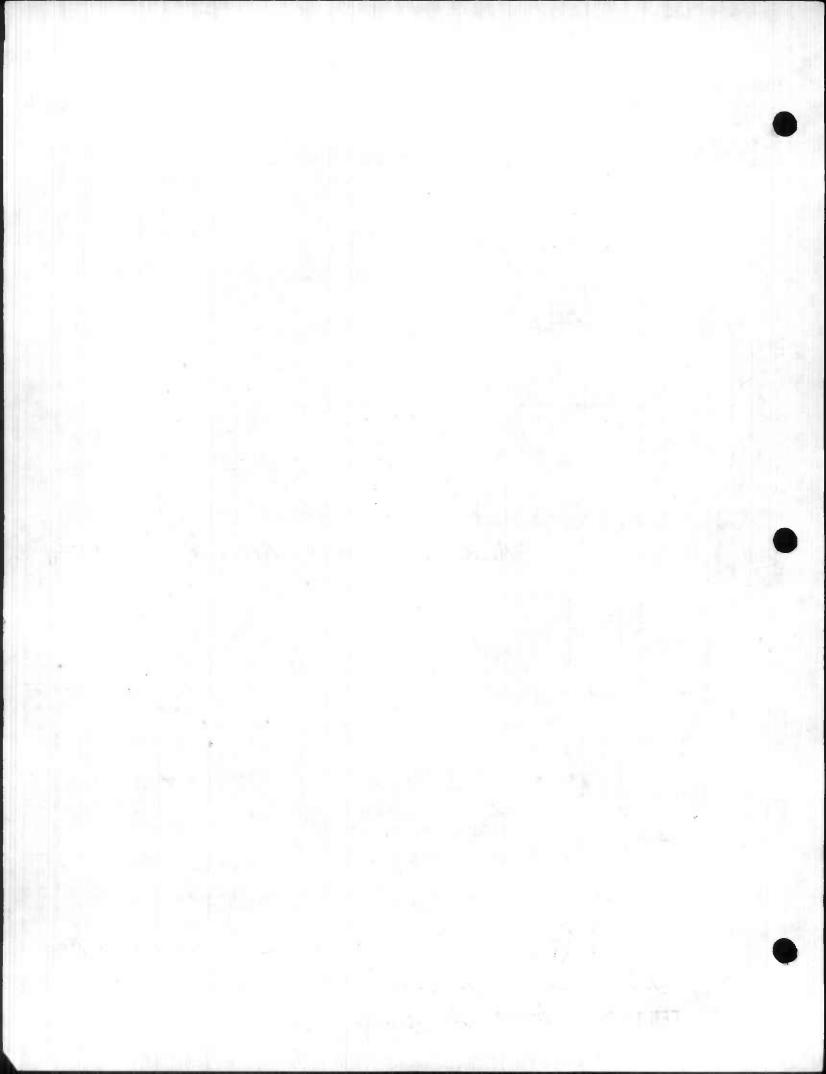
31. Date tiled (Month, Dey, Year) FEB 1 5 2000



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State of Maryland / Department of Health and Mental Hygiene O O Ly 7 | Ly

				Certificate of	Death	F	Reg. No.		r\$ 1 r\$		
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Physician /Medical	HWWE	T. I C	re:T			Febru	cary 14	2000	1:52 A		
Examiner	4a Facility Nama (If not institution,	give street and number)			4b. City, Town, or Loc	ation of Death	4c. County	of Death			
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Funeral Director	062-05-8140	40 M 40 F	(In yrs. last b	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birtl (Month, Day AUG 24	v, Year)		lace (Stata or Foraign try) York		
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	11. Merital Status 12. Was Decedent Ever in U,s Armed Forcas?			13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Specan, Maxican, Puarto F	cify Yas or No-	14. Rac	e - Amarica k, Whita, a			
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72 hg	15. Decedent's (Specify only highest		16	. Decedent's Usual Occup (Giva kind of work dona	eation		16b. Kind of Bu	ısinass/Ind	lustry		
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alth TT	Arlene Icart/	daughter	7	7341 Swan I	Point Way	7, Col	umbia,	MD	21045		
Semit. Pages 1 end Department of Health mportant: If Item 27 my injury or other to MGB.	20a. Method of Disposition		20b. Place	of Disposition (Nama of ary, cramatory or other place	cel	Data	20c. Location -	City or To	wn, Stata		
	1 Burial 2 Topemation 3 4 Donatlon 5 Other (Spe	Removal from Stata		o Crematory,	1	5/00	Ralti	more	MD		
	21. Signature of Funerel Service Lie	ss of Facility	2/15/00 Baltimore, MD ety of Maryland, Inc.								
Depa Impo	I Flaurice	Michimo	W	Crematio	on Societ	y of	Maryla	ind,	Inc.		
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hed hed	Part II. Other significant conditions	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.						23b. Did tobacco use contribute to the cause of death?			
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N	30. Name and eddress of person wh	o completed cause of dea	th (Item 23a)	(Type, Print) Little Paruyzay	DI PI		2	1			
	JERRY I I	Exicon /1		Little HATUYEN	phy (ole	MOAN (m 2	1044			
State	31. Data filed (Month, Day, Year)	32. Registrar	s Signetura		•						
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** 0139 Havol 07 10 2000 Jones ' /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore Hospital Baltimore Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (fn yrs. lest birthday) If Under 1 Year Birthplace (State or Forms Country)
 NC **Funeral** Days 217-18-0199 100M 2□ F Months 87 Yrs. Director Feb. 15, 1912 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f show treumstic event, the Medical Examiner mail the mothled at MD N/A XDE Yas 2 □ No Director Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1203 Idylwood Road 21208 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1♥ Yes 2□ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Montal Hygiens. Important: if item 27 is marked other than "natural; or fle any injury or other traumatic event, the Manalesia Examina 1 Never Married 277 Married Baltimore, Maryland 21215-0020 1 Yes XX No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Steel Mill 3 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Charlie Jones Cora Young 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Lucy Miller / Daughter 1203 Idylwood Road, Baltimore Maryland 21208 20b. Place of Disposition (Name of cametery cremetery or other place) 20e. Method of Disposition 20c. Locetion - City or Town, State 1 Burlal 2 Cremation 3 Removal from State Greenwood Baptist Church Cem. Feb. 13,2000 Warrenton, NC 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Eunerel Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Fine) disease or condition resulting in deeth) Examiner Examiner Hizheimers be executed physician and s the bunal-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): stroke Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the detached Records, P.O. signed by t 3 Probably 4 Unknown 1 Yes 2 No COPD 2 24b. Were autopsy lindings available prior to completion of ceuse of death? 24e. Wes en autopsy Completed peeu 1 ☐ Yas 2 No 1 Yes Division of Vital 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) examiner' Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes X No 2 1 Minpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Certification: After 5 Pending Investigation 1 Neturel Injury N/A death. 1 Yes 2 No 2 Accident or Attend after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital of 24 hours a Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated.

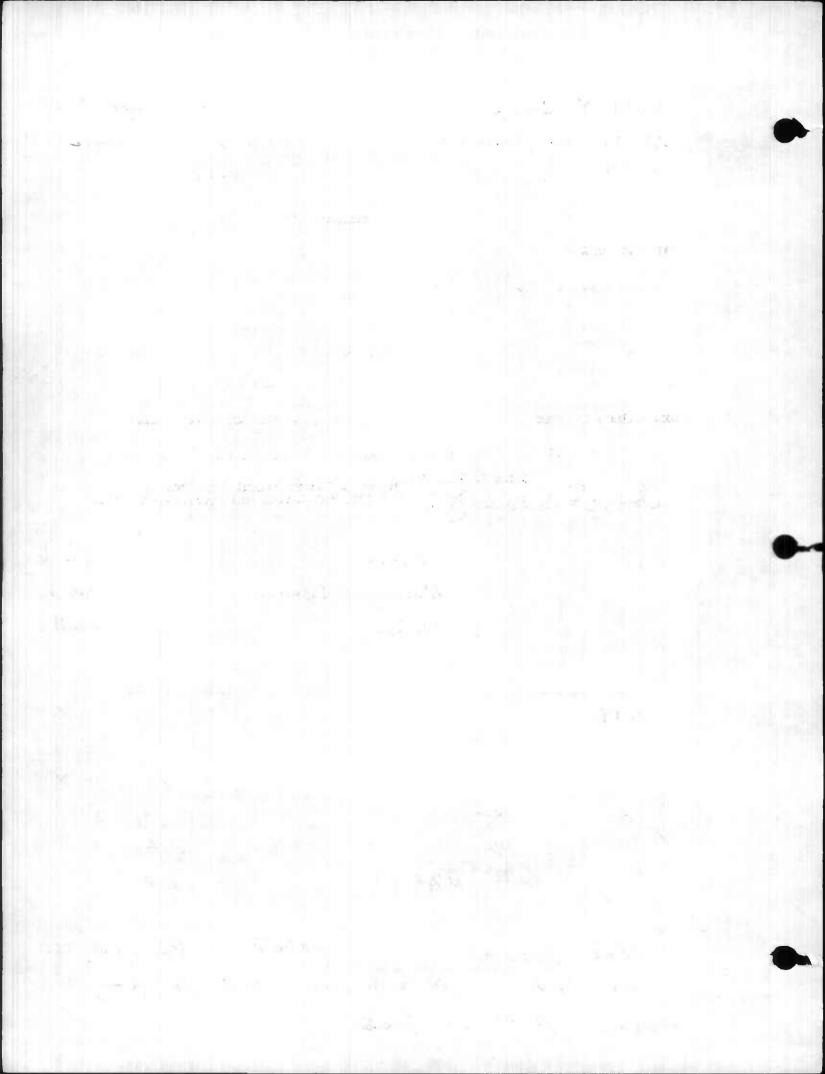
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) 29a. Certifier Medical and manner stated. To the To the To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 13-10667 271 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ordes Greene Street, Bultimore South

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year)

1 5 2000

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth 13,2000 **Physician** ERMA 240 AM February /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimure City Hospital Maryland

5. Social Security Number General If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, **Funeral** 1 □ M 20 F Months Days Hours 214-22-8095 Usual Residence of Decedent **Director** the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MI) 10e. Street and Number 10g. Citizen of What Country? 6 Rema 23a death , Funeral 12. Wes Decedent Ever in U,S. Armed Forcesi 1 ☐ Yes 2 DNo If Yes Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or frem any injury or other traumatic event, the Medical Exercises once. Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No war Specify: þ 3 ☐ Widowed 4 ☐ Divorced mericas Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life. PQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) iddary (0-12) Elementa Will 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Na me (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relation Method of Disposition Mmore, MD 2/2/7 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 1 Burial 2 Gremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic getimore, MD21217 I that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory the on each line. 23 Part1. Enter the disease, or complication shock, or heart failure. List only one can Approximete Interval Between Onset and Death **Physician** /Medicai immediate Cause (Final neumonia disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner Rebrovascular physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Due to (or as e consequence of): signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy peen 1 Yes 2 14 No 1 ☐ Yes 2 ☐ No certificata To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica complataly filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗆 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manper of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 🗆 No Investigation 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2/13/2000 hunch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sudle Menachery, M.D. Go Ma

maryland

32. Registrar's Signature

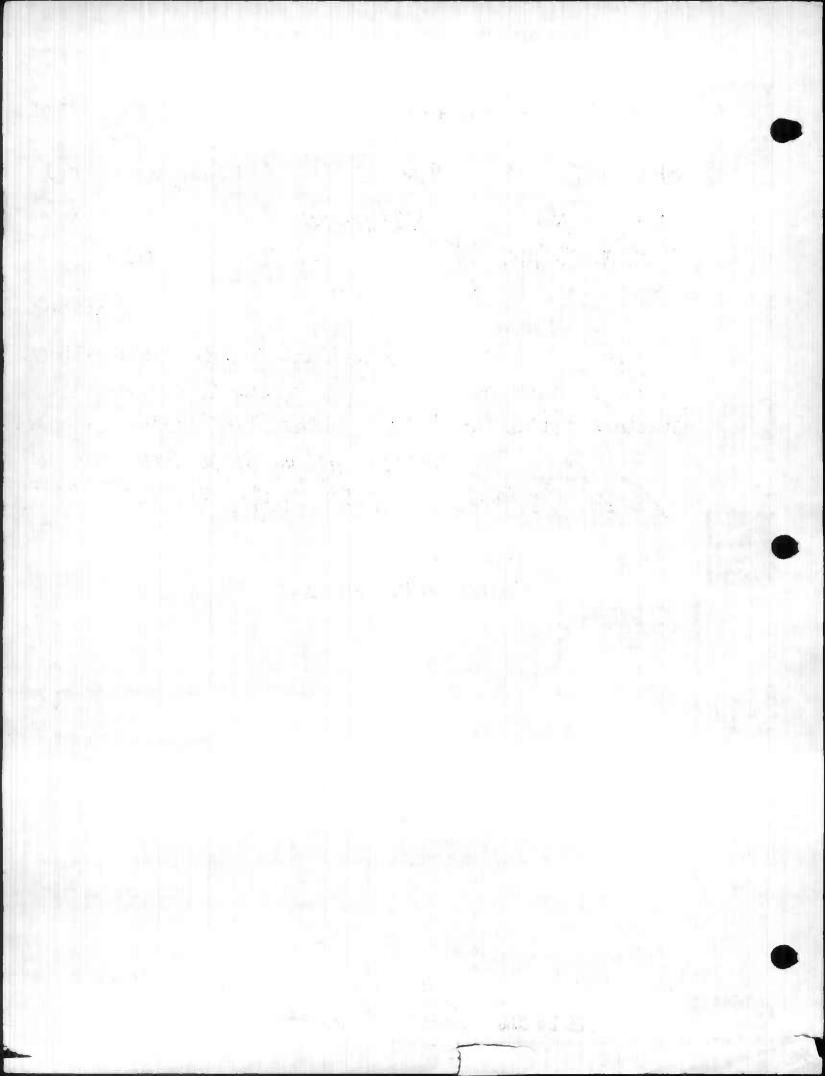
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31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

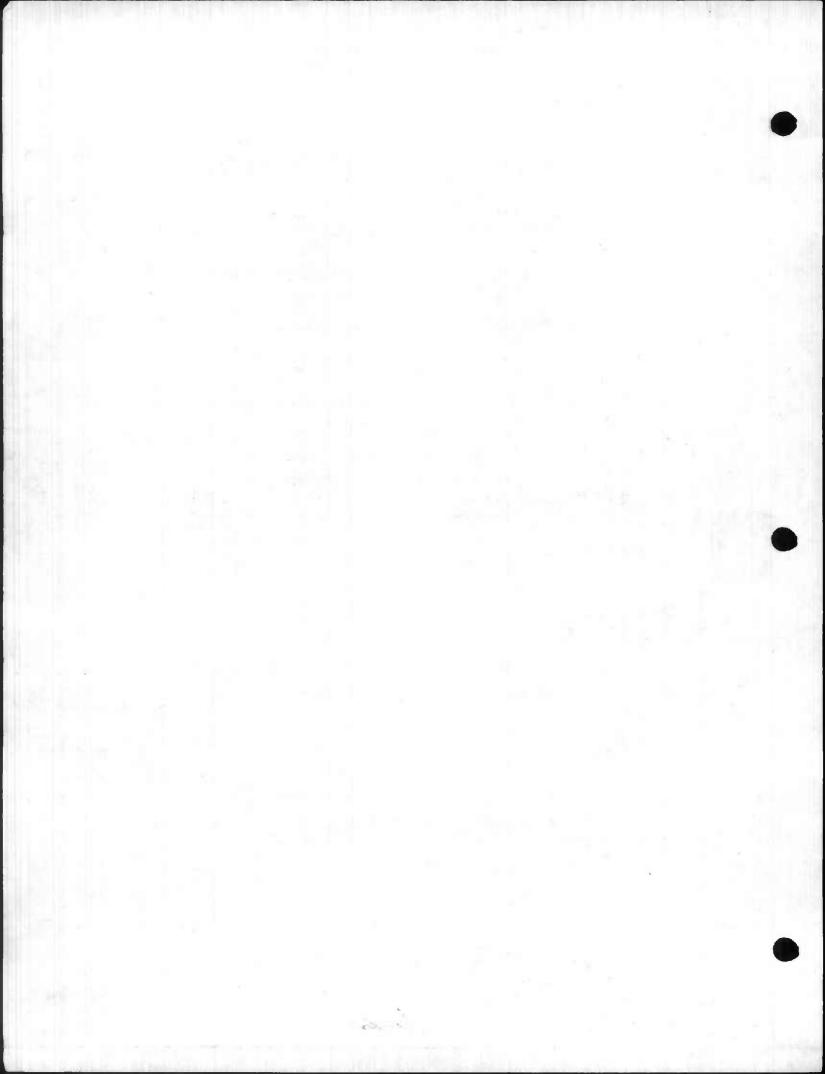


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State of Maryland / Department of Health and Mental Hygiene 0 0 17 7

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	Funeral		Social Security Number 6. S	Sex 7. Age (In	yrs. last	birthday) Yrs.	Months Day:		Min. (Month,	Birth Day, Year)	9. Birth	place (State or Foreign intry)	
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	nin Hilbert		1√Nevar Marriad 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 Yes 2 No Specify:			ruento rucan, etc.)			white	
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	6		30. Name and address of person who	completed cause of death	(Item 23								
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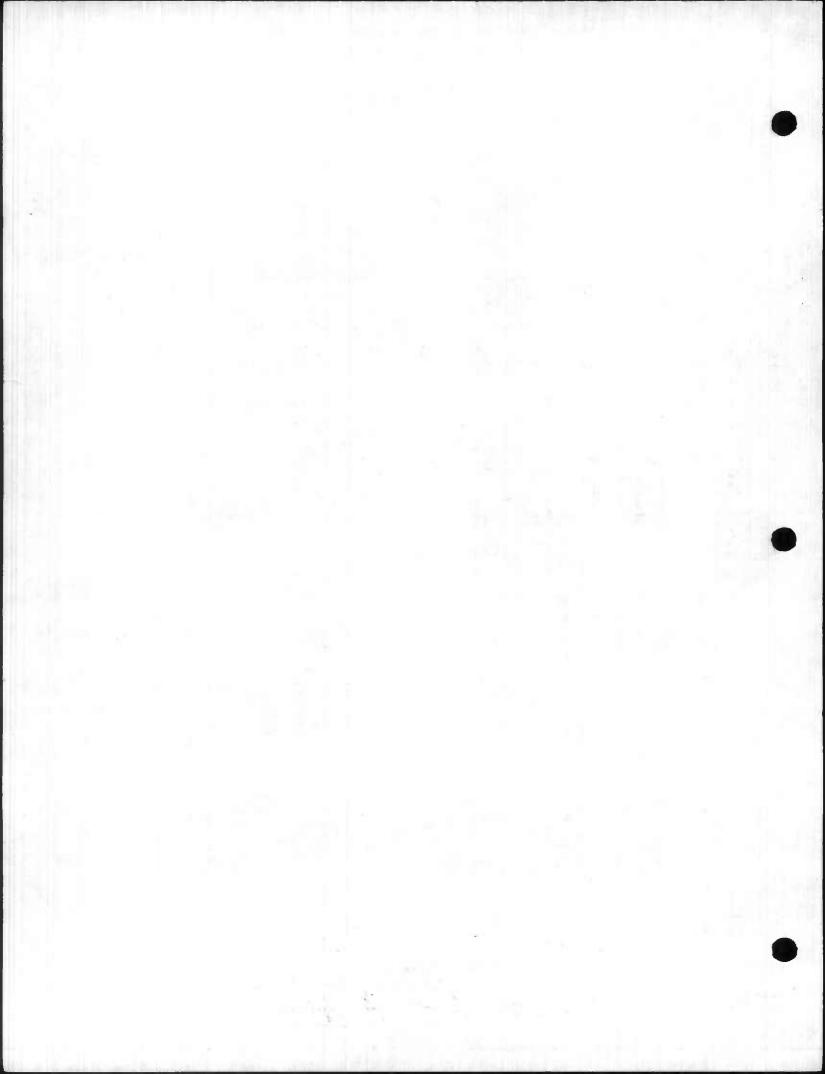
DHMH 16 Rev 6/95



February 10, 2000 10:00 P.M.

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Direc	10	10e. Street and Number 10f. Zip Code 21085							10g. Citizen of	What Count	ry?	
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Piease Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Amended Items#24a,b per FHG780 2/15/2000 EW 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death February 13, 2000 **Physician** MARGARET MIANULLI 8:15A.M. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Charlestown Nursing Center Catonsville Baltimore If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey,) 01 / 15 / 6 Sax Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months. Days Hours Yrs. 1925 Ohio 75 Director 289-22-0236 Usual Residence of Decedent the Menyland 10c. City, Town or Location 10a Stata 10b. County 10d. Inside City Limits ahow Itam 27 is marked other than "natural", or flems 23a or 28a-f ahor other traumatic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Catonsville Maryland 10e. Street and Numbar 10g. Citizen of What Country? 10f. Zip Code United States of America 717 Maiden Choice Lane #507 21228 Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) pernit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Important: If Itam 27 Ia marked other than "natural", or Ita any Injury or other traumatic avent, the Medical Example. 1 Yas 2 No 1 Nevar Married 2 Married 1□Yes 210 No Baitimore, Maryland 21215-0020 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Domestic Homemaker 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Michael Juhasz Anna Hornyak 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V. James Mianulli/ Spouse 717 Maiden Choice Lane #507, Baltimore Maryland 21228 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removel from Stete Crest Lawn Memorial Gardens 2/18 Mariottsville, Maryland 4 ☐ Donelion 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Neme end Address of Facility David J. Weber Funeral Homes, P.A. UESP Pher 5311 Edmondson Ave. Baltimore, Maryland 21229 23a. Part1. Entar the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respirelory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Sepsis disaase or condition resulting in deeth) Examiner Due to (or as a consequence of): Gallstones Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buriel Box 68760, Physician/Medical Dua to (or as a consequence of): P.O. I 23b. Did tobacco use contribute to the cause of death? Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 (No 3 Probably 4 Unknown Division of Vitai Records, by 24b. Were sutopsy findings available prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? 1 ☐ Yes 2 No certificata Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 2 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28h Time of Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not ba 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certitier (Check only one) Medical pletely To the Vithin 2 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar Maiden

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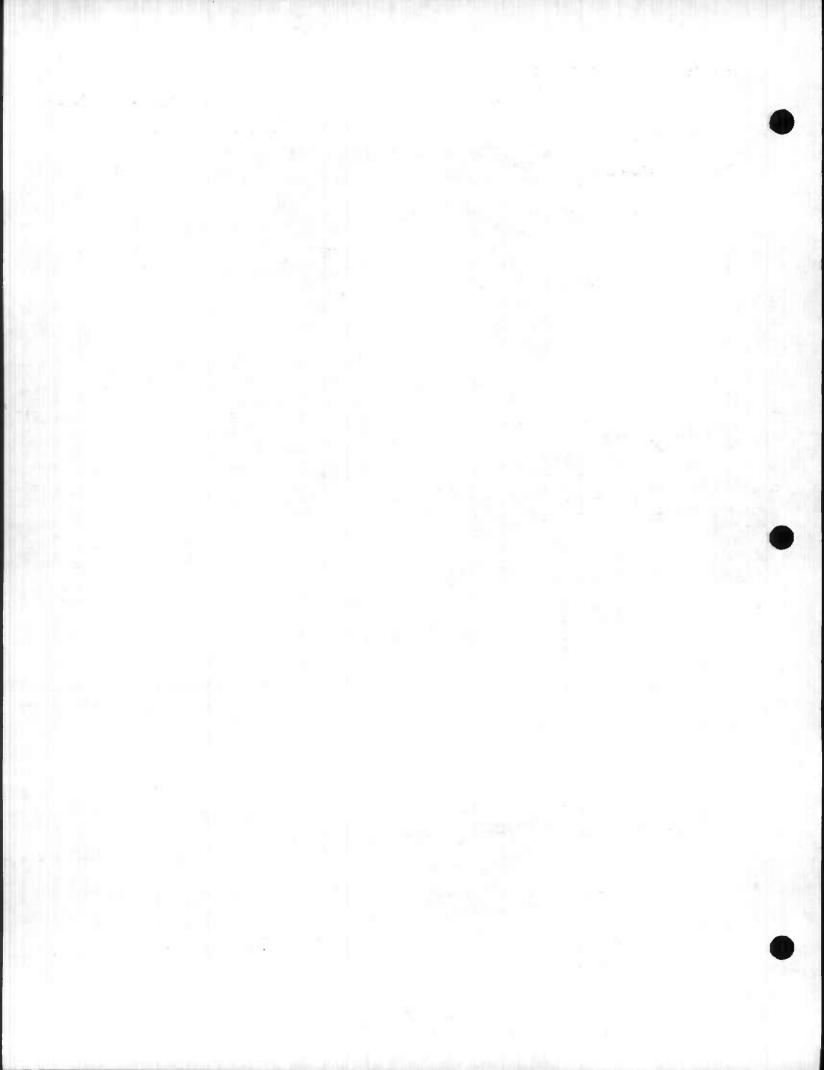
31. Date filed (Month, Dey, Year)

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32. Registrar's Signeture

Choice Lang

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Ada E. McClary EBRUARY 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Stella Maris Hospice at Mercy Hospital Baltimore City 5. Social Security Number 212–12–9076 If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 35 F 98 Yrs. November 1, 1901 Director Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show Maryland N/A Baltimore City Director XX Yes 2 □ No Nems 23s or 28s-f must be notif 10e. Street and Number 1 West Cornway Street 10f. Zip Code 10g. Citizen of What Country? 21201 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give natural, or White 1 Yes 2√ No Specify: Specify à 3€Widowed 4 □ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 0 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Department of Health and Mental Important: if Item 27 is marked i any injury or other traumatic ev James E. Marsh Ada E. Hill P 19a. Informent's Name/Relationship (Type, Print)
Patricia J. Busch / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 Homewater Way, Unit # 203, Glen Burnie Maryland 21060 20b. Piece of Disposition (Name of cemetery, cremetory or other place)
Green Mount Cremetory 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 255 Cremation 3 ☐ Removel from Stete February 12, 2000 Baltimore City, MD 4 ☐ Donaiion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. 22. Name and Address of Facility Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of). Examiner pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 94 Due to (or as a consequence of) Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Ninknown 1 ☐ Yee 2 ☐ No à 24b. Wera autopsy findings available prior to Completed 24a. Was an eutopsy performed? completion of cause of death? page 2 1 Yes 2 No 1□ Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) STE//A MARIS axaminer? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOSDICE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Manger of Death 28a. Dete of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of After 1 Natural 5 Panding 1 Yes 2 No death. 2 Accident Investigation Director: / 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide filled in 24 hours a Cartifying Phyelclen: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and manner stated. 29e. Certifier Medical To the Fune completely f

filed within 72 hours after

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital or Attending Physician:

Hospital

Vithin 2 To the

Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Day, Year) 5.2000

Ih

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

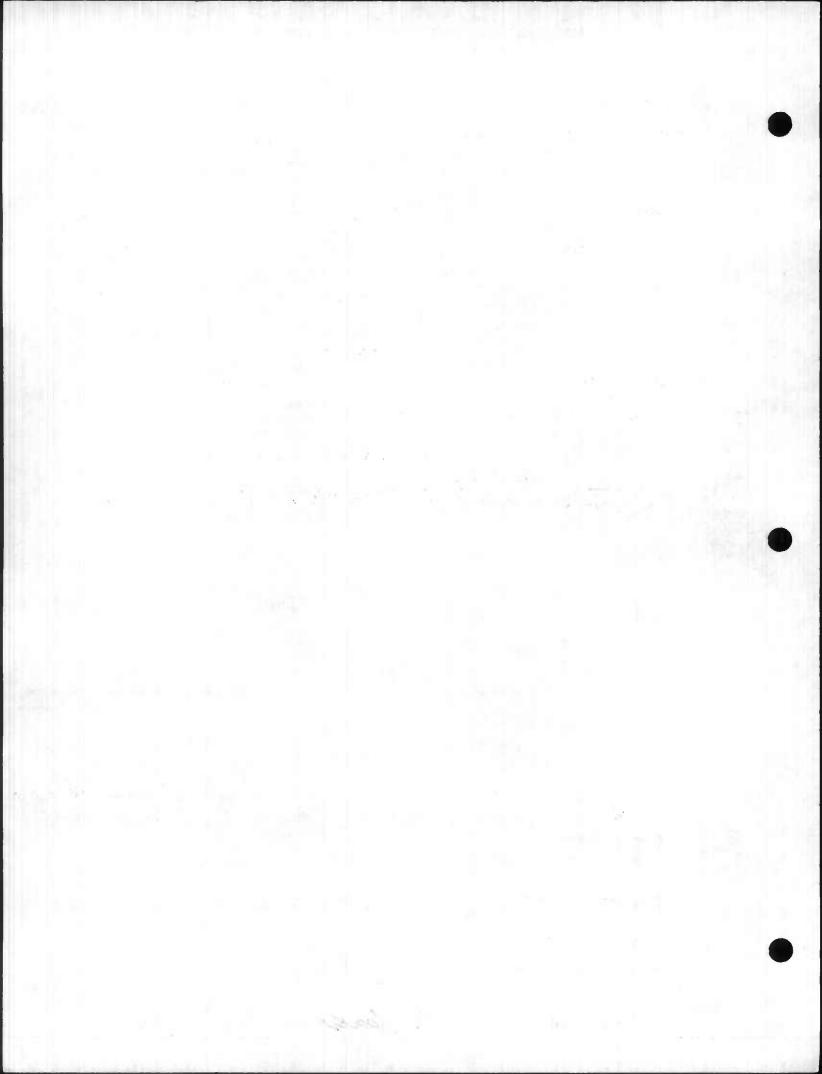
RISZ DERG 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Dey, Year)

BAH: MORE MDal202

FEBRUARY 11, 2000

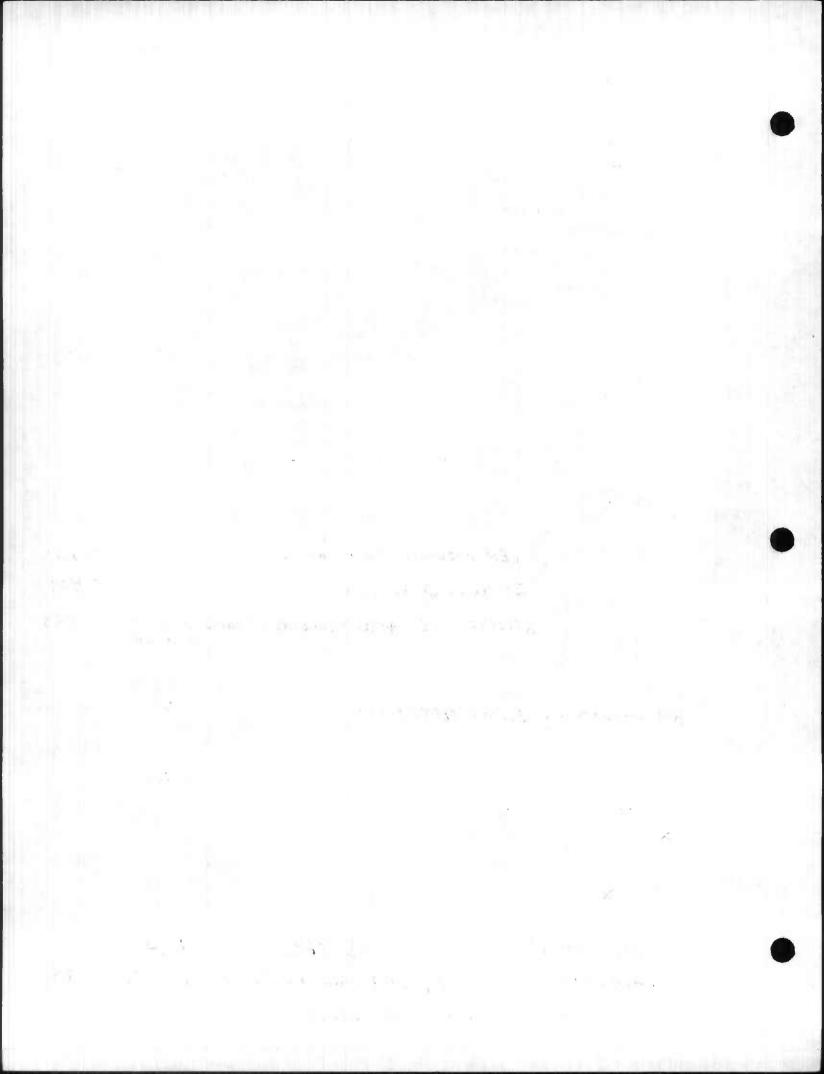


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State of Maryland / Department of Health and Mental Hygiene O O

	Certificate of Death	Reg. No.	0 04/21								
Physicia	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	Year 3. Tima of Death								
/Medica	FRANK BENJAMIN MC CRAY	FEBRUARY 13	1,2000 4.41 111								
Examine	+ 4a Facility Name (If not institution, give street and number) . 4b. City, Town, or L FRANKLIN SOUALE HOSPITAL CENTER RUSEI		BALTINGLE								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)								
Director	214-07-1067 US M 2 F 89 Yrs. Months Days Hours Min.	Oct. 24 1910	Maryland								
Pag Ba	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits								
to Mary Ba-f sh stiffsd.	MD Baltimore Middle Riv 10e. Street and Number 10f. Zip Code	rer	1 ☐ Yes 2 💢 No								
		τ	of What Country? JSA								
020	4U3 PICOLE RIVET ROAD 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto It Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Specify Cuban, Mexican, Puerto It Yes, Give Year or Dates:		s or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: White								
72 h	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Machinist	16b. Kind (of Business/Industry								
121 Pan Pan	Elementary/Secondary (0-12) College (1-4or 5+)										
d 2 Hygie ther in	8th Machinist 17. Father's Name (First, Middle, Lest) 18. Mother's Name	B & e (First, Middle, Maiden Sui	& O Railroad								
land of the contact o	17. Father's Name (First, Middle, Last) Frank McCray Sr.	Grace Crou									
Should My man	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur										
Baltimore, M omit. Pages 1 and 2 Apartment of Health, important: if them 27 is my Injury or other tra	Gwendolyn McCray / wife 405 Middle River F 20a. Method of Disposition 1 Redurlat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Placa of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery 2/ 21. Signature of Funeral Service Licansee	Date 20c. Locati	ore Md. 21220 ion-City or Town, State altimore MD								
W SOUTH	R Thunk Connelly Fune	eral Home o	f Essex								
	23a. Part 1. Enter the disease, or conflications that caused the duan shock, or heart failure. List arm one cause on each line.										
Physician /Medical	Immediate Cause (Final		Onset and Death								
Examiner	disease or condition resulting in death) a. VEP I COULAR INCUMP (AM) A		BOMIN.								
	Due to (or as a consequence of):		5 yrs								
and Il-transit	Sequentially list conditions, if any, leeding to immediate cause Finer Underlying		3 77-3								
6876(CUUDIONICO	IE 10 YRS								
ords, P.O. Box (requires that the death certification signed by the attending hould be detached for use a	Description of cause given in Pert 1. August 11. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. August 12. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. August 12. Other significant conditions contribute to the cause of a limit of the cause of th										
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dS, Fines that signed d be del	All the House to Still to the S										
0 > 00 .		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?								
Vital Relations The law certificate has rector, page 2		1□ Yes 2XN	lo 1 Yes 2 No								
/ital		th (Check only one)									
Of Vita Physician: this certific	exeminer? 1 Yes 2 No	Home 5 Residence 6 Other (Specify)									
After fune		28d. Describe how injury occurred									
- P#FE	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)									
Hospi 24 hou Funer stely fil	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To the within the complete com	29b. Signature and little of cartifler My 18642	29d. Date s	igned (Month, Day, Year)								
Police	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) — NAMAMEM	RALT. U	12 21237								
State Registra	31. Date liled (Month, Day, Year) FEB 1 5 2000 32. Registrar's Signature Separate Aparts										
	I MA WA MAAA										

DHMH 16 Rev 6/95



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Yaar **Physician** Robert Murray 4b. City, Town, or Location of Deeth 8:57PM /Medical 2000 4a Facility Nama (If not institution, giva streat end number) 4c. County of Deet Examiner 1 of Baltimore Baltimore If Under 24 Hrs. 8. C 5 Nai Hospita 5. Social Security Number If Undar 1 Year 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Min. 218-10-7502 Months Davs Hours 15 M 2 F 86 Yrs. Director TROY Usual Residence of Decedent with the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 77 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Mexical Examiner main be notified at 1 Yes 2 No Md. Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 Funeral 5615 death 12. Wes Decedent Ever in U,S. Armed Forcas? Race - American Indian, Bleck, White, etc. Was Dacedant of Hispento OrlgIn? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 11. Meritel Stetus 1 ☐ Yas 2 M If Yes, Give Yaer or Detes: 1 Nevar Married 2 Married 2 No altimore, Maryland 21215-0020 Black 1 Yes 25€No þ Completed Decedant's Usual Occupation (Give kind of work done during most of working life. DO NGT use retired) 15. Decedent's Educetion (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) abores 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 86 amie orace Murra 2 19e, Informent's Neme/Reletionship (Type, Plint) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heelth e Important: if Item 27 Is any Injury or other trax DRCs. addon 5615 21201 ary urra 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition City or Town, State Dete 1 Buriel 2 Cremetion Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cem. 22. Nama and Ad Douglass 21. Signature of Funeral Service Licenses Nama and Address of Fecility Service Funera 1701 Mc Culloh an 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Daath **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical TERMINAL ASPIRation Examiner Due to (or es e consequence of) Physician/Medical Examiner Prieumonia ettending physicien end for use as the buriel-transit Sequentially list conditions, if any, leeding to immadiete cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence of): certificete be execu Due to (or es a consequence of): rasulting in deeth) Lest signed by the e 23b. Did tobacco use contribute to the cause of death? P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Wera autopsy findings aveileble prior to 24e. Wes en autopsy performad? Completed completion of cause of death? hes page 2 2/1 No certificate Hospital or Attanding Physician: 25. Wes cese referred to medicel examiner? Be 26. Plece of Deeth (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 70 1 Inpatient 3□ DOA 2 ☐ ER/Outpetient After this funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 5 Pending Investigation 1 Natural 2 🗆 No 1 Yes 24 hours after death. 2 Accident Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical

29c. Licansa number

29d. Date signed (Month, Day, Year)

12, 2000

Februages

To the Vithin 2

completely

(Check only one)

MARCUS

29b. Signature end title of certifier

D:

FEB"15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith, MD

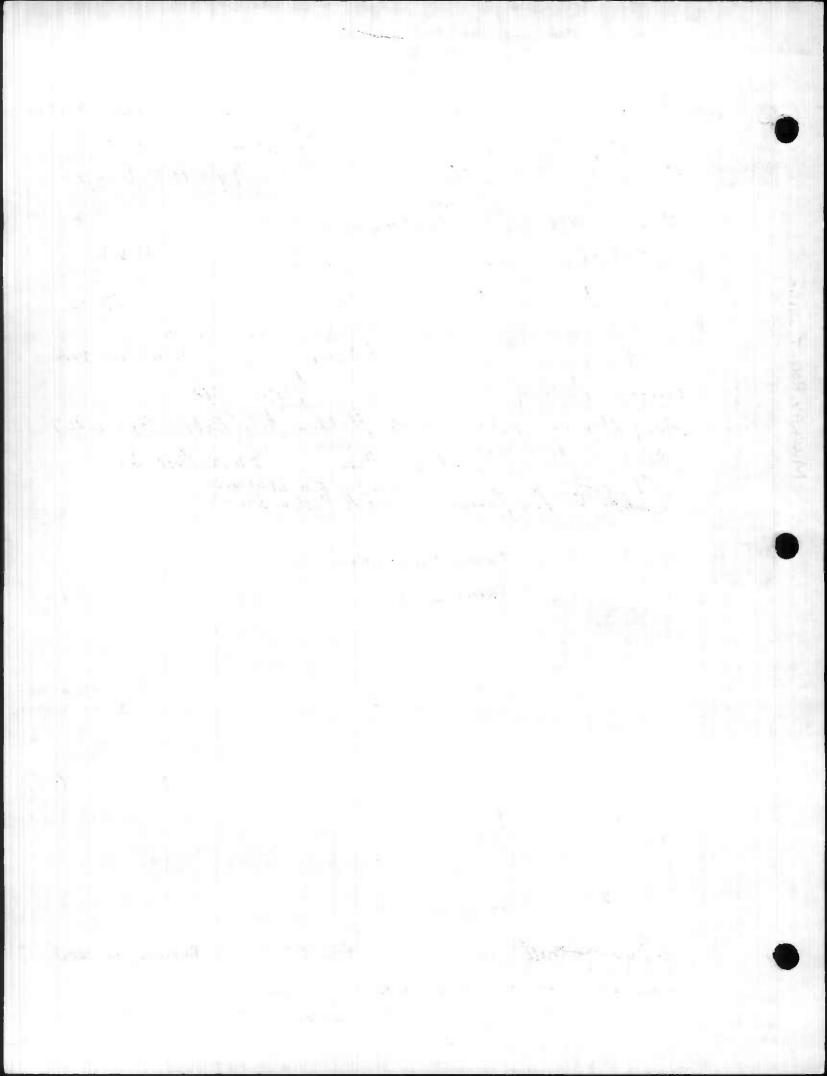
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2000³². Register's Signeture

Hospital

MURRAY, Robert Willie

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amended items 5,7,8 per informant g782 4/25/2000 ah Reg. No. 1. Decedeni's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Пау Month Physician McCroer arolee ebruary /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death But more
If Undar 24 Hrs. 8. Dat 8. Data of Birth 4/9/31 (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Months Director 120 Usual Rasidanca of Dacedani 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yas 2 □ No Director MARVLAND 10e. Street and Number 10f. Zip Code 10g/ Citizen of What Country? ò KOAD "natural", or items 23a USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 Yas 2 No 14. Race - American Indian. 11. Marial Status Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: If Yas, Giva Yaar or Datas: þ BLACK 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: if frem 27 is marked other than any Injury or other traumetr. Collega (1-4or 5+) GRADE ICENSED PRACTICAL NURSE SPRING GROVE HOSPITAL VR5 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be LARENCE JONES GENEVIEVE 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3925 BONNER ROAD, BALTIHORE, MD, 21216
Data 20c. Location - City or Town, State MONYETTE CHASE SMITH (DAUGHTER) 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20a. Mathod of Disposition Data 1 Burial 2 Cremation 3 Ramoval from Stata ZION CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 02-14-00 LANSDOWNE, MARYLAND 22. Nama and Addrass of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 2140 FULTON N BALTIHORE, MD. 21217 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest shock, or haert feilure. List only one cause on each line. Approximate interval Batween Onset and Death **Physician** /Medical immedieta Causa (Final disaasa or condition rasulting in daath) Examiner Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Diseese or Injury that initiated events rasulting in death) Last and Dua to (or as a consequence of Box 68760, physician Physician/Medical Dua to (or as a consequence of): usa Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No atrial Records, þ 24b. Ware autopsy findings evailable prior to complation of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No certificata Division of Vital or Attending Physician: 25. Was casa rafarrad to medical examinar? director, Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mennar of Death 28b. Tima of 28d. Describe how injury occurred Aftar 1 Natural 2 Accidant To the Hospital ...
within 24 hours after death.
To the Funeral Director: Air 5 Pending 1 Yes 2 No invastigation 6 Could not be datarmined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To tha best of my knowledga, death occurred at the time, data and piece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Neme and address of person who completed causa of death (item 23a) (Type, Print) 3 Data filed (Month, Day, Year) 32. Registrer's Signeture State

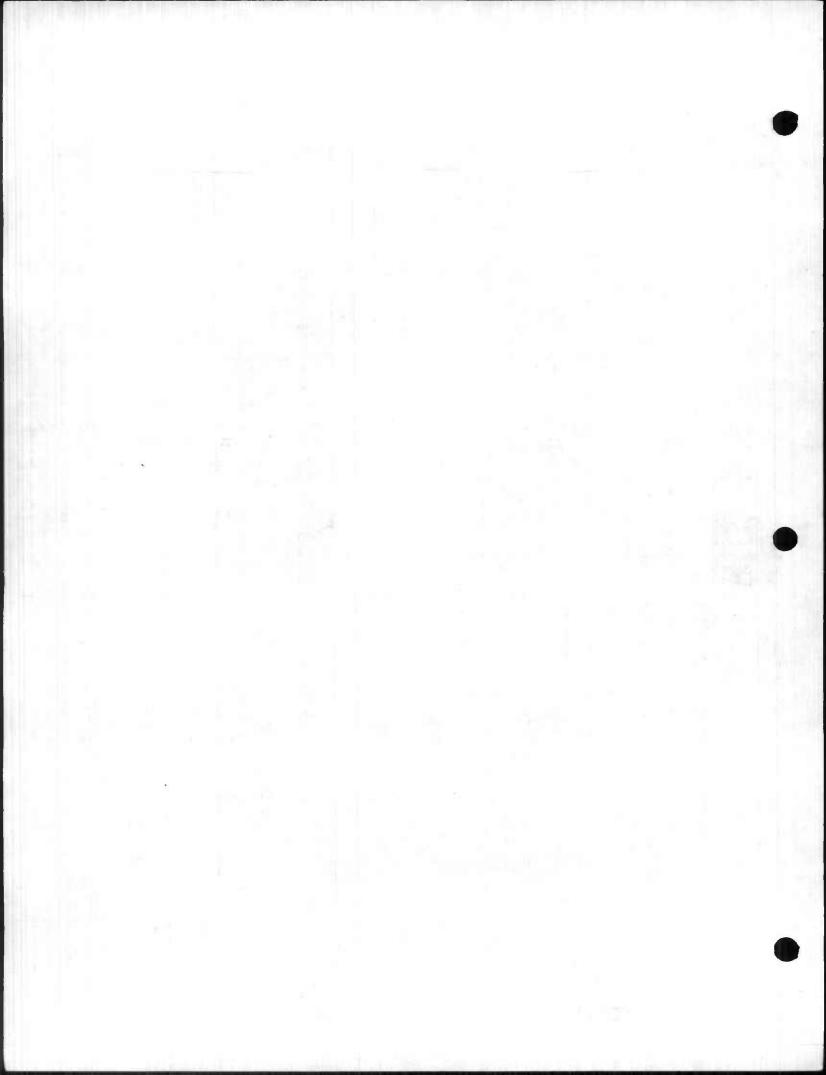
DHMH 16 Rev 6/95

Registrar

FEB15

2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #17, 18 PER F.H. G780 2-15-2000 WR. Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12.40 **Physician** MOSES EDDIE 2000 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner SPECIALTY HOME SHOSPING BALTIMORE BALTIMORE DEATON If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplace (State or Foreign Country) Months Days 248-18-748 Yrs. JAN. 01, 1917 SOUTH CARRINA **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE CIT Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 209 STRICKER STREET USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Rece - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Merital Status 1 Never Merried 2 Married 1□ Yes 2XNo Specify. by ACK 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WORKER RAILROAD 10 +H GRADE avant, II 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any Injury or other traumatic avent, blace. 17. Fether's Name (First, Middle, Last) EDDIE MOSES RRIE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 209 STRICKER ST. BALTIMORE, MD. 21223 Te of Date 20c. Location - City or Town, State INDA MOSES (DAUGHTER) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Surial 2 Cremation 3 Removal from State 02-15-00 LANSDOWNE, MARYLAND ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIHAKE, MD. 21217 ulver 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory argeshock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 3 month Examiner Physician/Medicai Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Diabeles Due to (or as a consequence of 98 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed performed' 1 Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical axaminer? 26. Plece of Deeth (Check only one) Hospital: 1 Annpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide

death certificate be executed physician and s the buriel-tran P.O. Box 68760, aftending p signed by the Division of Vital Records, page 2 s Hospital or Attanding Physician: After To the Hospital or Attanding within 24 hours efter deeth.
To the Funeral Director: After completely filled in by the fun.

with the Maryland

death

filed within 72 hours after Hygiena.

altimore, Maryland 21215-0020

28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier

(Check only one) 29b. Signature and title of certifier

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

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29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

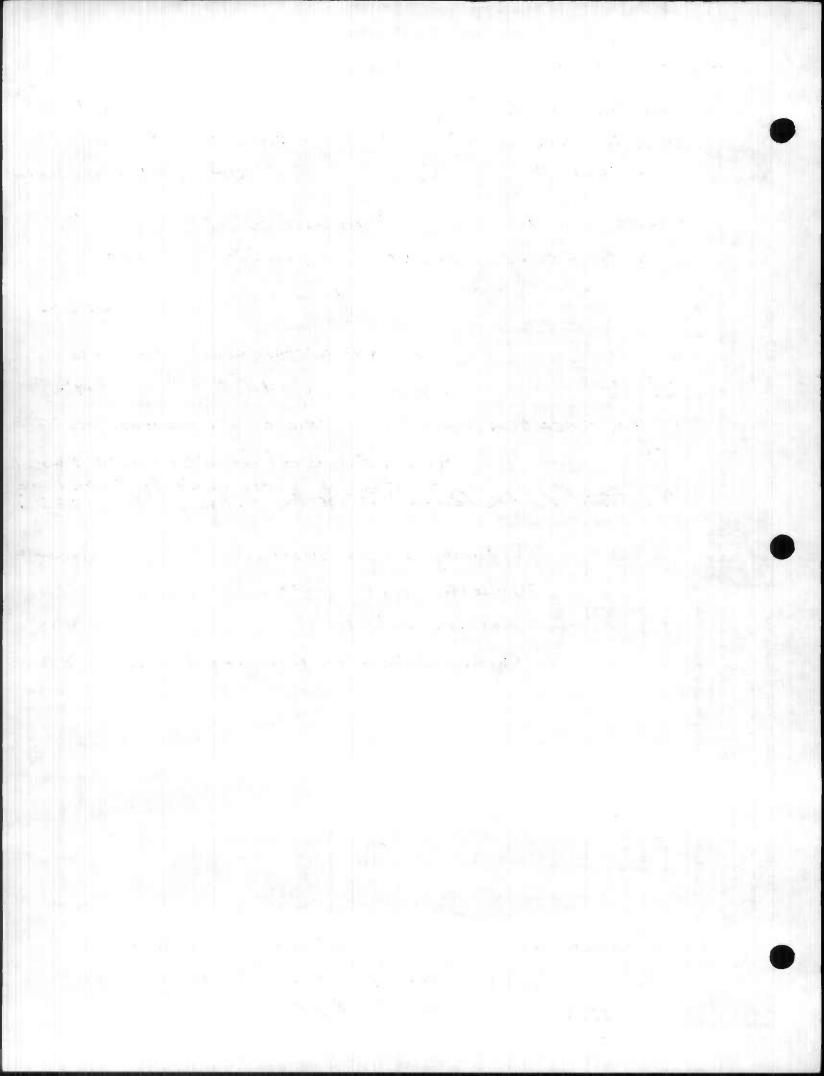
8775 cloudleap ct, #224, Columbia, MD 21045 CHARLIMEHTA, MD.

Registrar

edicai

31. Date filed (Month, Dey, Year) FEB 1 5 2000

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** Charles 14, William McKinney, Sr. FEB. 2000 4:30am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health of Bel Air Bel Air Harford 7. Aga (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) JAN 9, 1927 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 1₽M 2□F 216-28-4400 73 **Director** Maryland Usual Residence of Decedent the Manyland 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yas 2 No Director Harford Fallston 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code With 410 Mountain Road permit. Pages 1 and 2 should be filled within 72 hours after death v. Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23s any injury or other traumatic event. The second 21047 USA Funeral 12. Was Decedent Ever in U.S. Agmed Forcas?
2 No. 944/
If Yes, Giva
Year or Datas: 1947 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yas 2 XNo Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Purchasing Agent Army 18. Mother's Nama (First, Middle, Maidan Sumame) 17. Father's Nama (First, Middla, Last) Be Roy G. McKinney Martha Ann Most 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 410 Mountain Rd., Fallston, MD Catherine A. McKinney/wife 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial X☐ Cremation 3 ☐ Removal from Stata Metro Crematory, Inc. 2/15/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22 Name and Addrass of Facility
Cremation Society of Maryland, Inc. McDonald Nonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner The law requires that the death certificate be axecuted **buriel-transit** Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) physicien s the buriel P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of deeth? 1 Yes 2 2NO 3 Probably 4 Unknown ate has been signed page 2 should be de Records. à 24b. Wara eutopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 XNo 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Assidence 6 Other (Specify) Medical Certification: To 1 Yas 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending invastigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stafa) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital 29a. Cartifier 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated. pletely (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. To the 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature end titla of certifier Feb. 14, 2000 30. Nama and eddrass of person who compl ed cause of death (Item 23a) (Type, Print) Bel AU MI) 2/014

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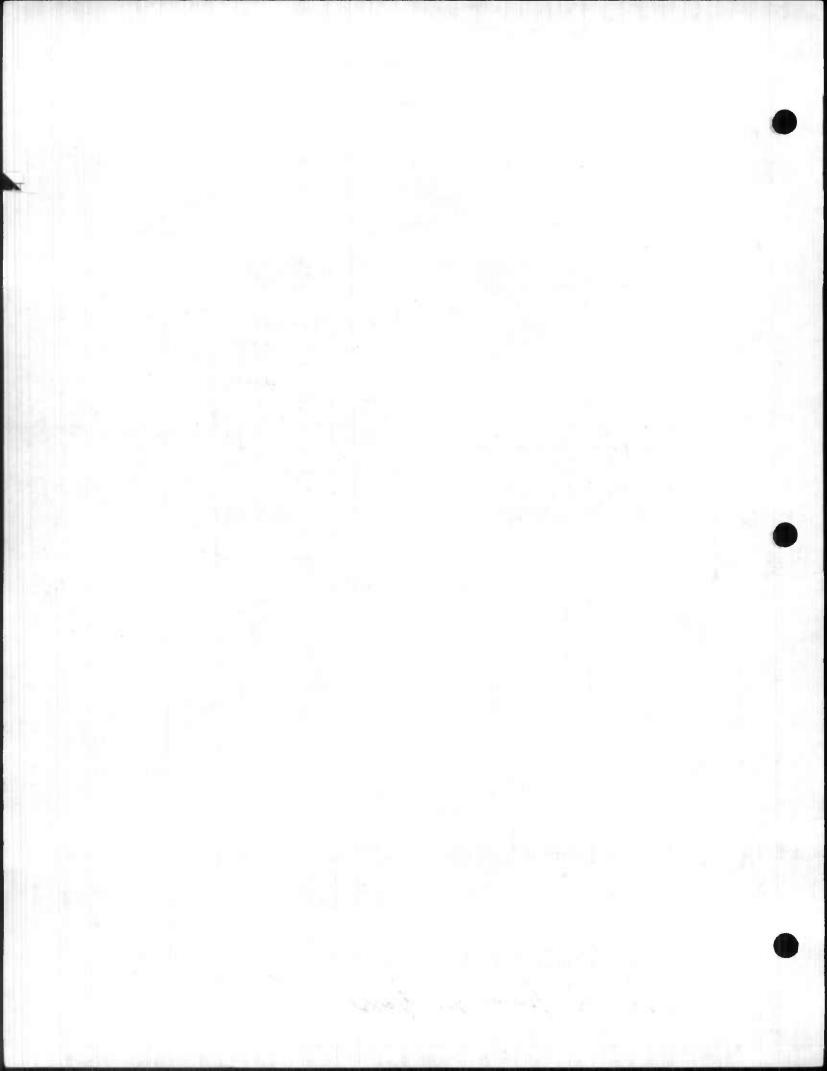
State

Registrar

31. Data filed (Month, Day, Year)

FEB 1 5 2000

32. Registrar's Signatura



Piease Type or Print in Biack indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day ebruary 10,2000 12:58P. Kamala I. Mehta 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Square Hospital Cen or 6. Sex [7. Age (In yrs. last birthday)] osedale enter H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yea 5. Social Security Number 9. Birthplace (State or Foreign Country) Days Months 10 M 20 F 90 233-11-6130 MAY 9, India Usuel Residence of Decedant 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Perry Hall Baltimore 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21236 USA 9501 Oak Branch Way 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yas 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Asian Indian 3 StWidowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Purshottam Mehta Devlaxmi Mehta 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 650 Grampian Blvd. Williamsport, PA 17701 Girish Mehta/son 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 2/11/00 Baltimore, 21. Signatura of Funaral Sarvice Uconsae Dawin F. McDonald 22 Name and Address of Facility Cremation Society of Maryland, Inc. Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death Immediata Causa (Final Hsystole disaasa or conditior rasulting in death) cardia Sequentially list conditions, if any, laading to immediate causa. Enter Undarlying Cause (Disaasa or Injury that initiated events resulting in death) Last iopulmonary Dua to (or as e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

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Funeral

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Norms 23s

the Medical Examiner

is marked other

reportant: If Item 27

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Mehta, Kamala Baltimore, Maryland 21215-0020

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be executed Box 68760. 94 P.O. Records, page 2 s Division of Vital Attending Physician: this within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Physician/Medical 2 Completed Be Certification: To

25. Wes casa rafarred to medical examinar? 1 Yes 2 No

27. Mannar of Death 5 Panding Invastigation 1 Natural 2 Accident 3 Suicide

6 Could not be detarmined

28b. Time of 28e. Data of Injury (Month, Day Year)

28c. Injury at Work? 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

rive Baltimore MD21237

28d. Describe how injury occurred

(Check only one)

4 ☐ Homicida

29e. Certifiar

Certifying Physicten: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number

29d. Data signed (Month, Day, Year) tebruary 10,2000

user 31. Data filed (Month, Day, Year) 000 Fran

32. Registrer's Signetura

address of person who completed cause of death (Item 23a) (Type, Print)

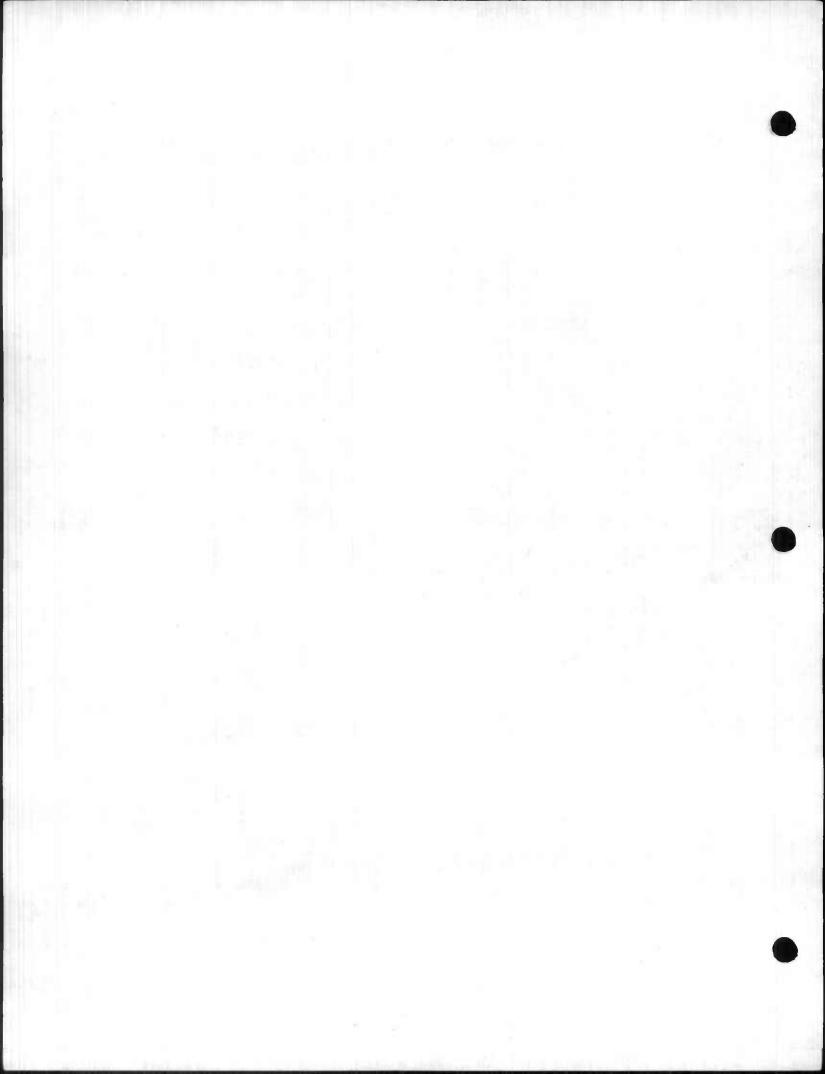
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within 2.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item#1 perPHYG 3/22/State of Maryland / Department of Health and Mental Hygiene Amended Item#17 perFH, Item#25, 27 perPhyG780 2/15/2000 Gertificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Das **Physician** Robert Mansfield Robert Edward Mansfield 23,2000 9:10PM Jan. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11945 Jerusalem Road Kingsville Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 6. Sex Birthplace (State or Foreign Country) **Euneral** Hours 10XM 20 F Months Days Director 68 June 21,1931 Balto.County, MD. 212-28-6706 Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c City Town or Location 10d. Inside City Limits show r 28a-f show 1☐Yes 2☑No Director Maryland Baltimore Kingsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? matter. U.S.A.
14. Race - American Indian, Funeral 11945 Jerusalem Road 21087 items : 12. Wes Decedent Ever in U.S.
Armed Forces?
1 Styles 2 Style
1 Yes, Give
Year or Dates: 1948/52 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status filed within 72 hours after 1 Never Merried 2 Merried 21215-0020 8 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 yrs. Engineer/Professional Elec. Whitman/Requardt & Asso Maryland 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If them 27 is marked of Luther G. Manfield Mansfield E. Theresa Luers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 11945 Jerusalem Road Mrs.Elizabeth L.Mansfield(Wife) Kingsville, MD.21087 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If Important: If any Injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 1/27/2000 Baltimore.MD. 22. Name and Address of Facility E.F.Lassahn Funeral Home 21. Signature of Funeral Service Liet 11750 Belair Road Kingsville, MD. 21087 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel scorne 1 da diseese or condition resulting in death) Examiner Examiner RELS The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Box 68760 Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown l be del Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performent? completion of cause of death? 1 Yes 2 Divis 1 Yes 2 No certificate funeral director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Attending 5 Pending 1 🖾 Naturel 1 Yes 2 No death. investigetion after death Director: 2 Accident the 6 Could not be determined To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

State Registrar

Medical

29e. Certifier

(Check only one)

29b. Signeture end title of certified

30. Name and address of person who completed de

31. Date filed (Month, Day, Year) FEB 15 2000

E.

32. Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. AMEND ITEM ! PER PHY. G780 2/15/00 yg State of Maryland / Department of Health and Mental Hygiene Certificate of Death YVETTE THERESA MALLORY 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:00P.M Yvelle 00 February /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MA Baltimore HOSPITAI If Undar 24 Hrs. 5. Social Sacurity Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 6. Sex 8. Dete of Birth (Month, Day, Year) **Funeral** Hours Days 1□M 257F Director 214-50-2516 Usuat Residence of Decedent 52 27 07 M.D 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 238 Funeral U.S.A.

4. Rece - American Indian,
Black, White, etc. 3804 Wabash Ave 21215 filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1XX evar Marriad 2 ☐ Merried Maryland 21215-0020 8 1 ☐ Yes 2 X No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced "natural", Black Be Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) erk City of Baltimore
18. Molher's Neme (First, Middle, Maiden Surmeme) 12th grade

17. Father's Neme (First, Middle, Last) Finance Clerk Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 is marked of To Elston Palmer Grace Washington 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5014 Pembridge Ave. 21215 Alyssia Paige-Daughter Baltimore Md Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta WBurial 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. 2/12/00 Randallstown, Md King Memorial Park 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Fecility March F/H West 23a. Part1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 21215 Approximate Intervat Between Onset and Deeth **Physician** Gastric CACCOMPLICATIONS /Medicat Immediate Cause (Finel disaesa or condition resulting in death) Examiner Examiner the death certificate be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and buriel-tran Due to (or es e consequence of): attending physician for use as the buriel Box 68760. Physician/Medical Due to (or es e consequence of): detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown The law requires that Division of Vital Records. by 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy performed? completion of causa of death? hes 1□ Yes 2₽No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 1 Yas 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Netural 5 Pending i effer death.

I Director: Aff
d in by the fur 1 Yas 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Dicompletely filled in edical 29e. Certifier 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) and menner steled. (Check only 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifiar 29c. License number RES GOO

DHMH 16 Rev 6/95

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State Registrar 2401 W. Belvedere Ave, Baltimore, MD 21215

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

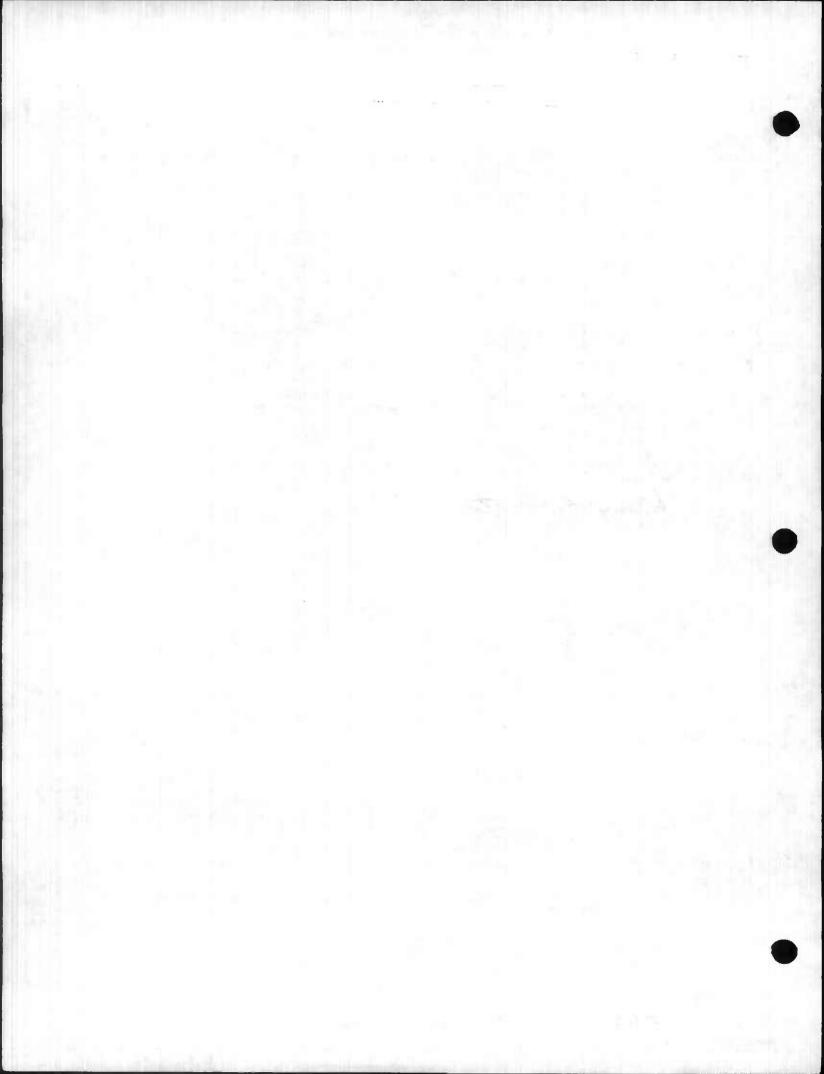
Rajapakse

32. Registrer's Signeture

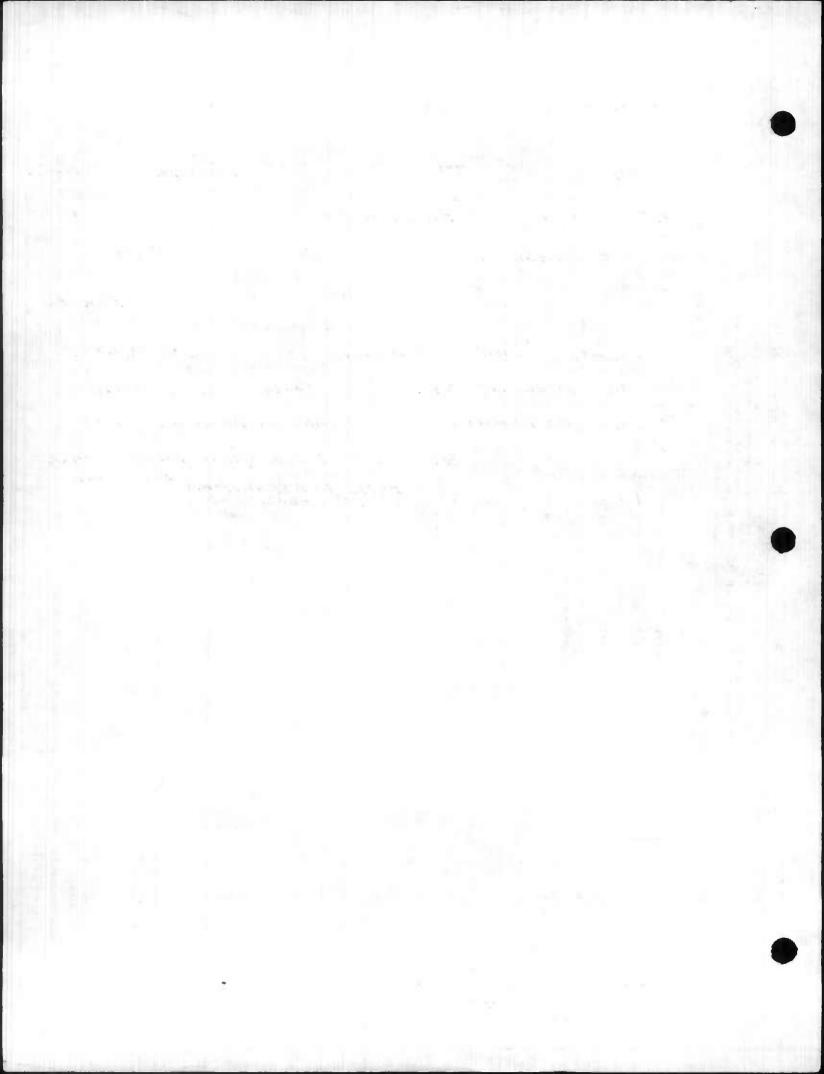
Sharlene

31. Data filed (Month, Dey, Year)

FEB 1 5 2000



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month Year **Physician** 6:10 p.M FE 2000 /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNESHEALTHUARE Bullmore 8. Date of Birth (Month, Day, Year) 900 caten MUE 5. Social Security Number

216 - 42 6394

Usual Residence of Decedent If Under 24 Hrs. 6. Sex 7. Age (In yrs. jast birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 M 2 Months Days Hours 55 Director the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits ahow r than "natural", or itema 23a or 28a-f ahor the Medical Example; must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3511 21229 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 S-No
If Yes, Give I
Year or Dates: Black, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Nem 27 Ia marked other than "natural", or ite. Specify: Ofrican 1 Never Married 2 Married 1 Yes 2 No Baitimore, Maryland 21215-0020 Specify. p 3 ☐ Widowed 4 ☐ Divorced american Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Colleger(1-4or 5+) Elementary/Secondary (0-12) 2th aborer Tee Cream 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tunsta Marin Tunstal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER Walfad, MD 20603 te 20c. Location - City or Town, State Vaughns Court Linda 2831 Harrison other 20a. Method of Disposition

1 ☐ Burial 2 SCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Injury or atonoville 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name and Address of Facility P. 21. Signature of Funeral Service Licensee abut 638 N Glemor St. Baltimore, MAZIZIT Approximate tnterval Between Onset and Death 23a Part T. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. **Physician** /Medical Immediate Ceuse (Finat Fulminant Metastate lung concer aweales disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): signed by the attending of the detached for use as Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27 Manger of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: Director: After 5 Pending Investigation Naturel I or Attendin after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confidence 000

DHMH 16 Rav 6/95

State

Registrar

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Charlotte

Miles,

AME

more MD 21044

30. Name and and track of person woo completed cause of death (Item 23a) (Type, Print)

FEB 15

32. Registrar Signature

31. Date filed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #4b PER MD G780 2/15/2000 AH Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Modth. Year **Physician** MISES ,25 Pm Feb 10 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA Hunder 1 Year severa) Dur If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-16-09 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 90 215-14-6771 VA. Director **Usual Residence of Decedent** death with the Maryland 10d. tnside City Limits 10s. State 10b. County 10c. City, Town or Location ahow must be notified at 1 Q Yes 2 □ No Director MD. N/A BALTIMORE 280-1 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6 2509 EDMONDSON AVE. 21223 IISA 238 Funeral Permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Heelth and Mental hygiene. Important: if Item 27 is merked other mental hygiene. Bridge. fleme : Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Marital Status Bleck, White, etc. Yes 2 No 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK py 3 ₩idowed 4 Divorced Year or Detea Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) -12-College (1-4or 5+) HOUSEKEEPING EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be ALFRED EWELL SR. MATTIE WARNER 19a. Informent'a Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LASHARON SHERMAN (DAUGHTER) 2509 EDMONDSON AVE. BALTIMORE, MARYLAND 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State METRO CREMATORY 2-12-2000 BALTIMORE, MARYLAND 5 Other (Specify) 4 Donation 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signeture of Funeral Service License Bree 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, whose, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical tmmediata Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner mony The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Completed by Physician/Medical 4 Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Wera autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? certificata has 1 Yes 2 No 1 Yes 2 No Attending Physicien: funeral director, 8 25. Wes case referred to medical examiner? 26. Place of Daeth (Check only one) Hospitat: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Meturel 5 Pending 1 Yea 2 No death. investigation 2 Accident after death Director: / 100 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) To the To the To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

DHMH 16 Rev 6/95

State

Registrar

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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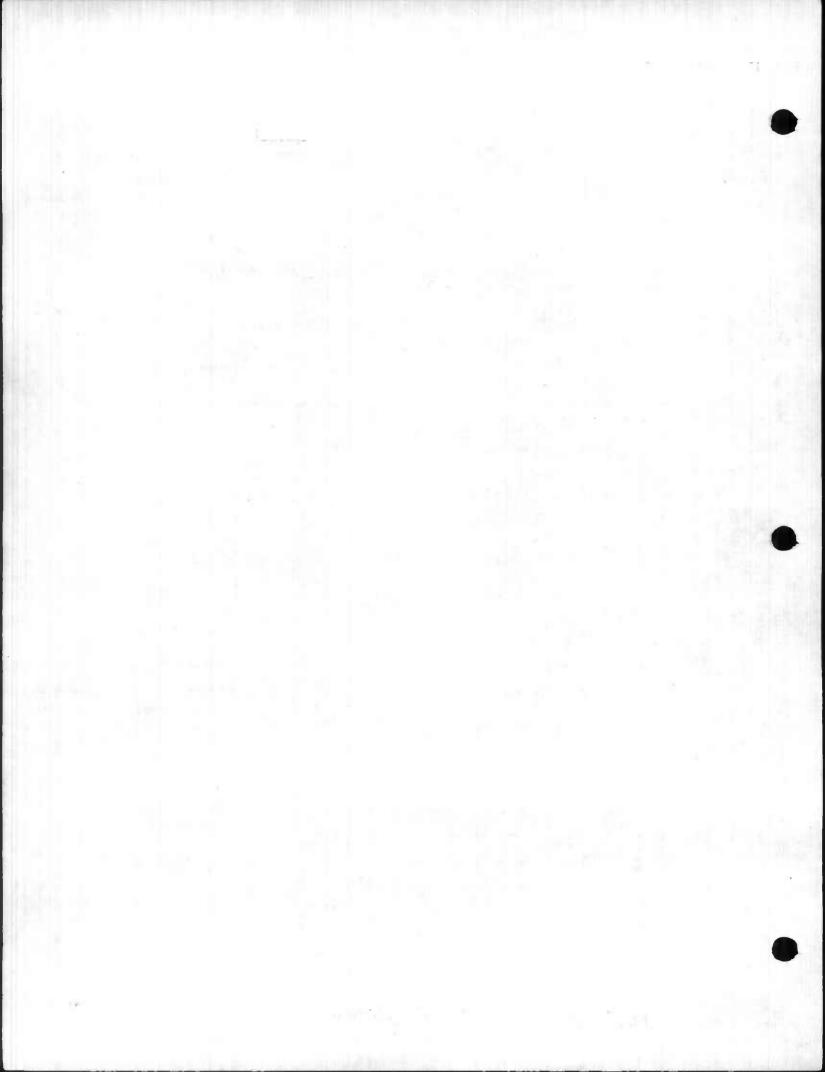
32. Registrar'a Signeture

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De Lean

31. Date filed (Month, Day, Year)

FEB 1 5 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month FEB 10, Mary M. Odell 2000 3:33 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 100 St. Ives Drive Park Severna Anne Arundel 8. Date of Birth (Month, Day, Year) AUG 27, 1920 If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country)
 Towns T 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 138-16-4677 79 Yrs. **Director** New Jersev Usual Residence of Decedent with the Manyland 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Anne Arundel 1 ☐ Yes 2 No Director Severna Park 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 St. 21146 USA death Funeral Ives Drive Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U,S. Armed Forcea? 14. Rece - American Indian, Black, White, etc. hours after 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specity: Specify: White by 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 should be filed wanted Mental Hygiers marked other the Homemaker Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic av Beatrice Corcoran Maurice P. McDonnell 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3245 Able Court Marietta, GA 30062 Lawrence N. Odell/son 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State
4 ☐ DongMon 5 ☐ Other (Specify) 20c. Location - City or Town, State Date Metro Crematory, Inc. 02/12/00 Baltimore, MD 21. Signatured Funeral Service Licensen ²² Name and Address of Facility Cremation Society of Maryland, Inc. Edward A. Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** myeloproliferative disorder /Medical Immediate Cause (Final 1241005 disease or condition resulting in deeth) Examiner Due to (or as a consequence of): 12 years Sideroblashic anemia **bunial-transit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical tha Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 200 No 3 Probably 4 Unknown nroat signed b conce Records. by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 ANatural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number weing MD anine D52830 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 10 900 Bestgate load, Annapolis, MD 21401 Canine werner, mis

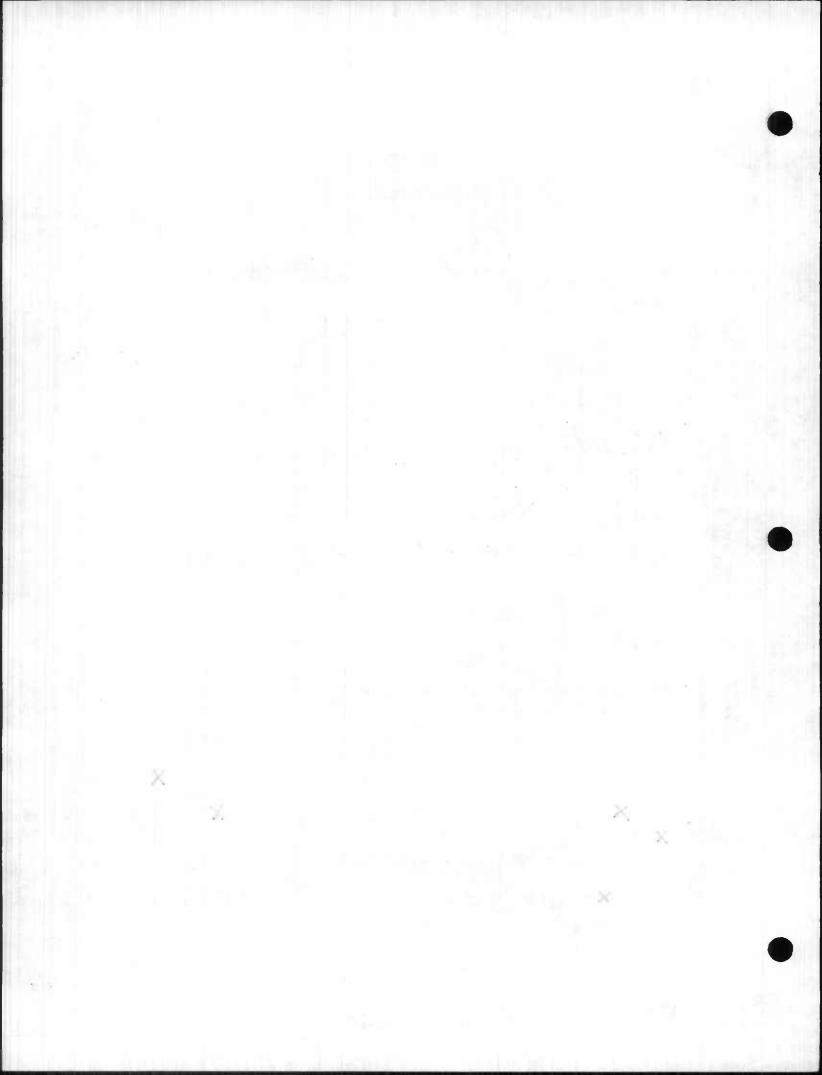
DHMH 16 Rev 6/95

Registrar

31, Date filed (Month, Day, Year)

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32. Registrar's Signeture

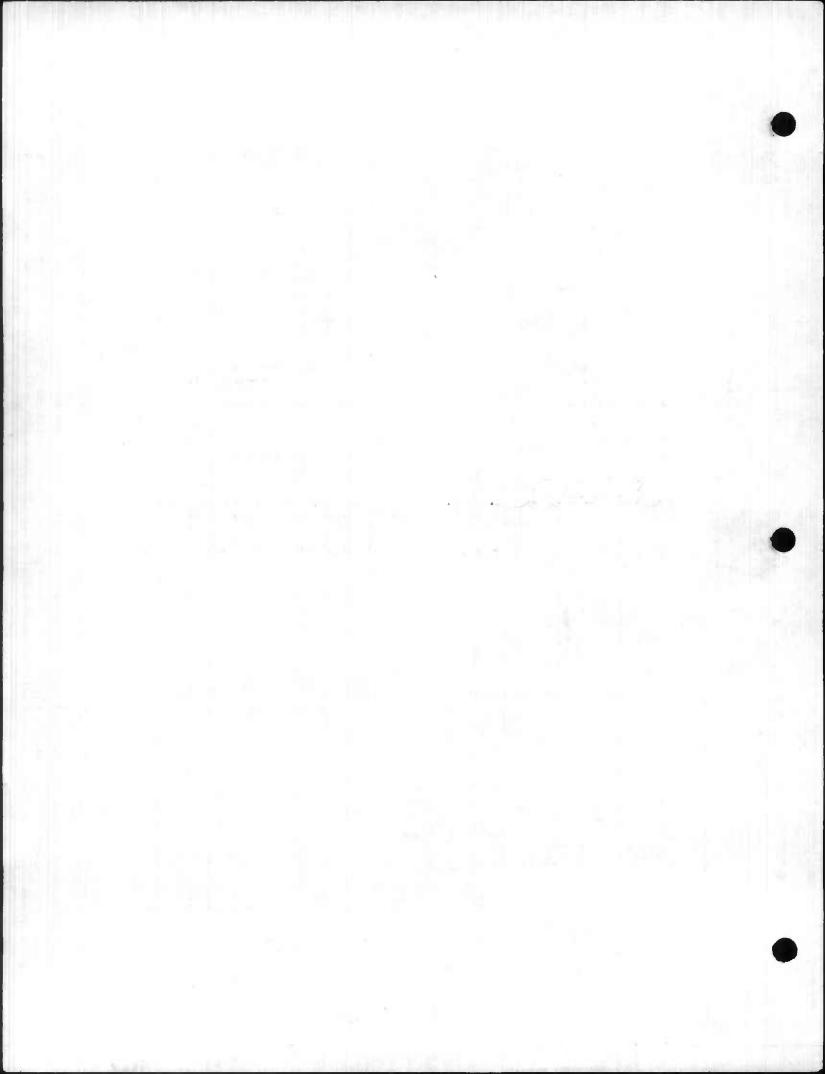


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** John Thomas Pearce February 11, 2000 12:50 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Pasadena MD Anne Anundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 215-01-6389-A 1 M 2 □ F 95 Director February 6, 1905 Maryland Usual Residence of Decedent Oa. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 25a-f show must be notified at Maryland Anne Arundel Pasadena Maryland 1 Yas XX No Directo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? "natural", or items 23a or 128 Sandy Beach Drive 21122 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours atter. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or the 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yes 20 No Specify: White Specify: à 3 DWidowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) LOngshoreman 0 Shipping 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be George Pearce Margaret Dunn 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores P. Hartlove / Daughter 128 Sandy Beach Drive, Pasadena Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removel from Stete Holy Cross Cemetery February 15, 2000 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1501 Fast Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Intervel Between Onset and Death **Physician** CONDUNALY ANTERY DISTASE /Medical Immediate Ceuse (Finel diseese or condition resulting In death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes > No 1 ☐ Yes > No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2/2√No 1 Inpatient 2XXER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? XX Neturel 5 Panding 1∏Yes 2∏No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier XX Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifing 0186 XD February 14, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1147 8. HAWOVER 57. POUNTA MARK 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Year 1:25 AM Feb. 2000 4a. Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death geriatric + lehab Center
7. Age (In vrs. last birthday) If Under 1 River Middle BALTIMOVE MALL Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year)
June 10 1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days 1 M 2 € KF 219-14-1986 88 Yrs. Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD **Baltimore** Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 142 Cowhide Circle USA 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2XXXX If Yes, Give Year or Dates: 1 ☐ Yes 201No Specify: White Specify: 3€Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Neme (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumame) John F. Schmelz Annie Knouff 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Sandi Dawson / niece 149 Cowhide Circle Baltimore MD. 21220 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holly Hill Cemetery 2/15/2000 Baltimore MD 21. Signature of Funeral Service Licens 22. Name end Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 23a. Part1. Enter the disease, or complications that caused the dual shock, or heart failure. List enty one cause on each line. Do not enter the mode of dying, such as cardiac or Acure 10-12 hrs Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Octoporons 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 8 Other (Specify) 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No

The law requires that the death certificate be executed the burial-transit Box 68760, P.O. Records, certificate Division of Vital De Hospital or Attending Physician: Inn 24 hours after death.

The Funeral Director: After this certifica in by the

Physician

/Medicai

Examiner

Funeral

Director

ral", or items 23a or 28a-f show

"natural".

Pages 1 and 2 should be filed within 72 honent of Health and Mental Hygiena.
int: If Item 27 Is marked other than "natur ury or other traumatic event, the Medical.

Department o Important: If any injury or

Physician

Examiner

/Medical

Director

Funeral

Completed by

Be

the Maryland

filed within 72 hours after death with

21215-0020

Baltimore, Maryland

Physician/Medical Examiner ρ Completed Be Certification: To

edical

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Naturel 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature engl title of cartifier M.D 29c. License number

29d. Date signed (Month, Day, Year) 38754 02-14-2000

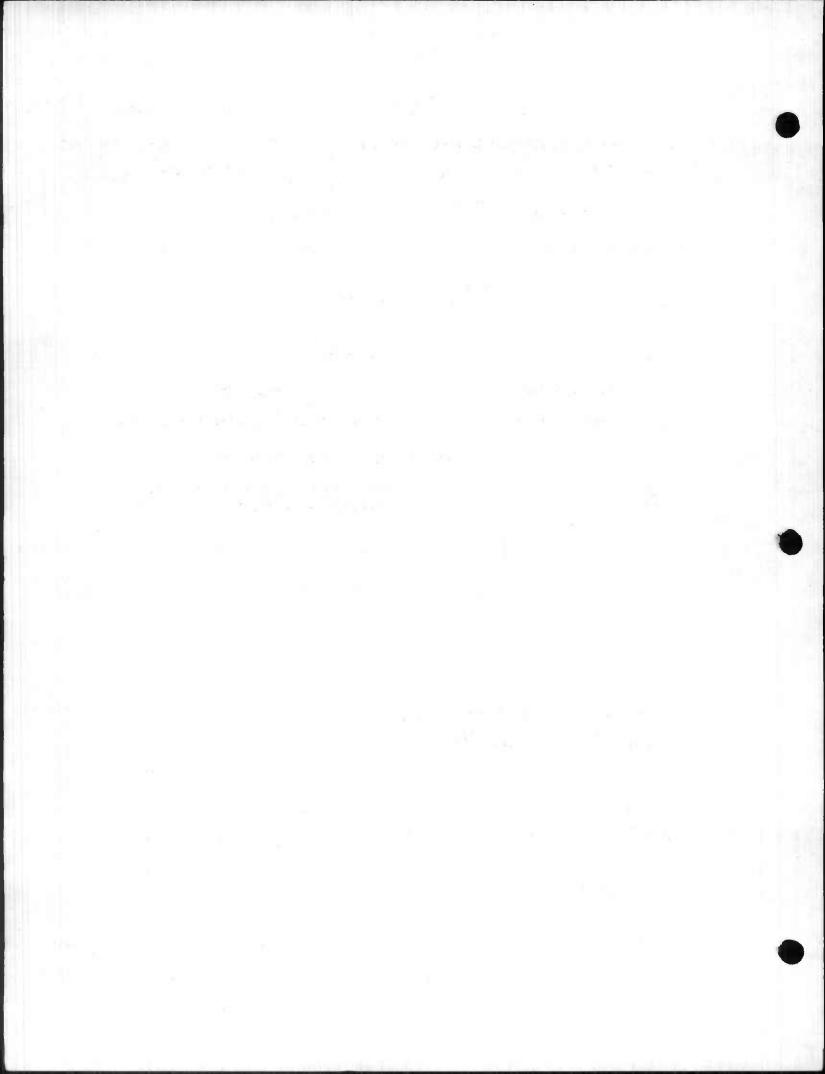
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ASTERN BLVD, MD - 21221 31. Date filed (Month, Dey, Yeer)

FEB 1 5 2000

32. Registrer's Signeture

State Registrar

Within 2 To the I



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar **Physician** 4:45 PK ouise 00 /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner 5. Social Security Number ORCa PL - ROMU 7. Age (In yrs. last birthday) la 8. Date of Birth 6. Sex 9 Birtholace (State or Foreign **Funeral** Months Days Hours 1□ M 2 5 05-948 212 Director Usual Residence of Decedant death with the Manyland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow the Medical Examiner must be notified at 1 ☐ Yas 2 No **Funeral Director** 288-1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 13. Was Decedent of Hispanic Origin? (Specify Yas or NoIf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 234 14. Race - American Indian, Black, Whita, etc. Нетв: 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status □Yas 20%No Yas Giva 1 Nevar Married 2 Married 1 Yas 1 ☐ Yes 2 No Specify: nite Specify: Be Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 62 MORD 20a. Method of Disposition 1 □ Burial 2 □ Cremation Feb. 15 20b. Place of Disposition (Name of 20c. Location - City or Town, State ery, crematory or other place) 3 Removat from State 4 ☐ Donation 5 ☐ Øther (Specify) emoter 2000 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility vans uneral (hase 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21234 Approximata Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) . arkrioselentecermony artery decesse /Medical **Examiner** Due to (or as a consequence of): Examine siclan and burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician the buria Physician/Medical Dua to (or as a consequence of): been signed by the attending p should be detached for use as Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 Yes 2 No Division of Vital Records. þ 24b, Ware autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy parlormed? page 2 certificate 1 Yes 2 100 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: Other: 4 Norsing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director; A the 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) Within 2 5 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) nerm 21022 15.00 Name and adde ed cause of death (Item 23a) (Type, Print)

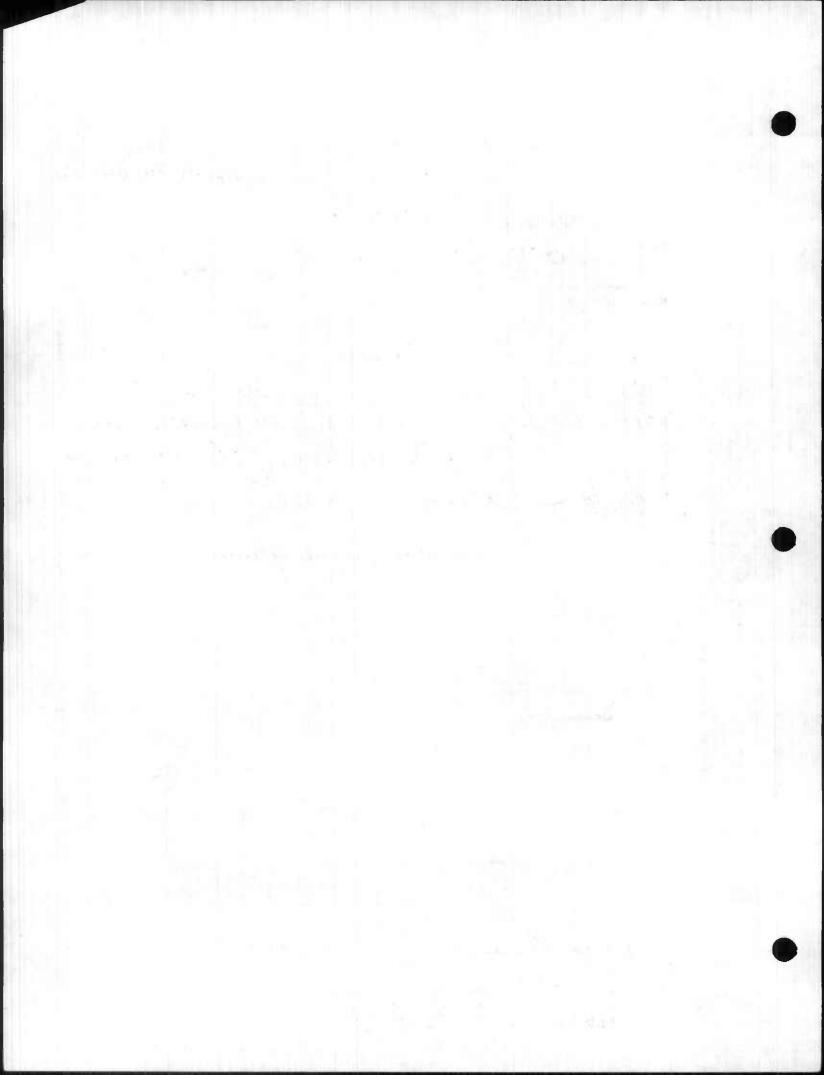
DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrer - Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month February 11, Virginia Ellen Preslev 2000 2010 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 2703 Riva Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 8,1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1□M 2√2 F 241-20-7178 75 Yrs. North Carolina Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2703 Riva Road 21401 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2XNo Specify: White Specify XXWidowed 4 ☐ Divorced Yaar or Datas 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Office Manager Food Service 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumame) Weldon Nelson Mattie Tucker 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Wilczenski (Friend) 2703 Riva Road, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, cremetory or other place) 02/14 2000 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from Stete King George, VA 4 ☐ Donation 5 ☐ Other (Specify) Historyland Memorial Park 21. Signature of Funeral Service Liceny 22. Name and Address of Facility Hardesty Funeral Home, P.A. ulla 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disaase or condition rasulting in death) Due to (or es a consequence of tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes, 2 No 1 ☐ Yes 2 ☐ No 25. Was code referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Yes, 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed and the burial-tran P.O. Box 68760, the attending physician hed for use as the buria signed by d Division of Vital Records. peed this certificate

Examiner Physician/Medical þ Be Completed Certification: To

Physician

/Medical

Examiner

Funeral

Director

must be notified

Nems 23s or 28a-f

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Hygiene.

hours after

Pages 1 and 2 should be filed within 72

Mental

and a

Department of Health at Important: if Item 27 is any injury or other trau 0058.

Physician /Medical

Examiner

Saltimore, Maryland 21215-0020

Director

Funeral

Aq.

Completed

Be

i or Attending Physician: after death. Director: After this certifice director. funeral in by the To the Hospital of within 24 hours a To the Funeral D bellif filled

State Registrar

Medical

29a. Certifier (Check only one)

29c. License number

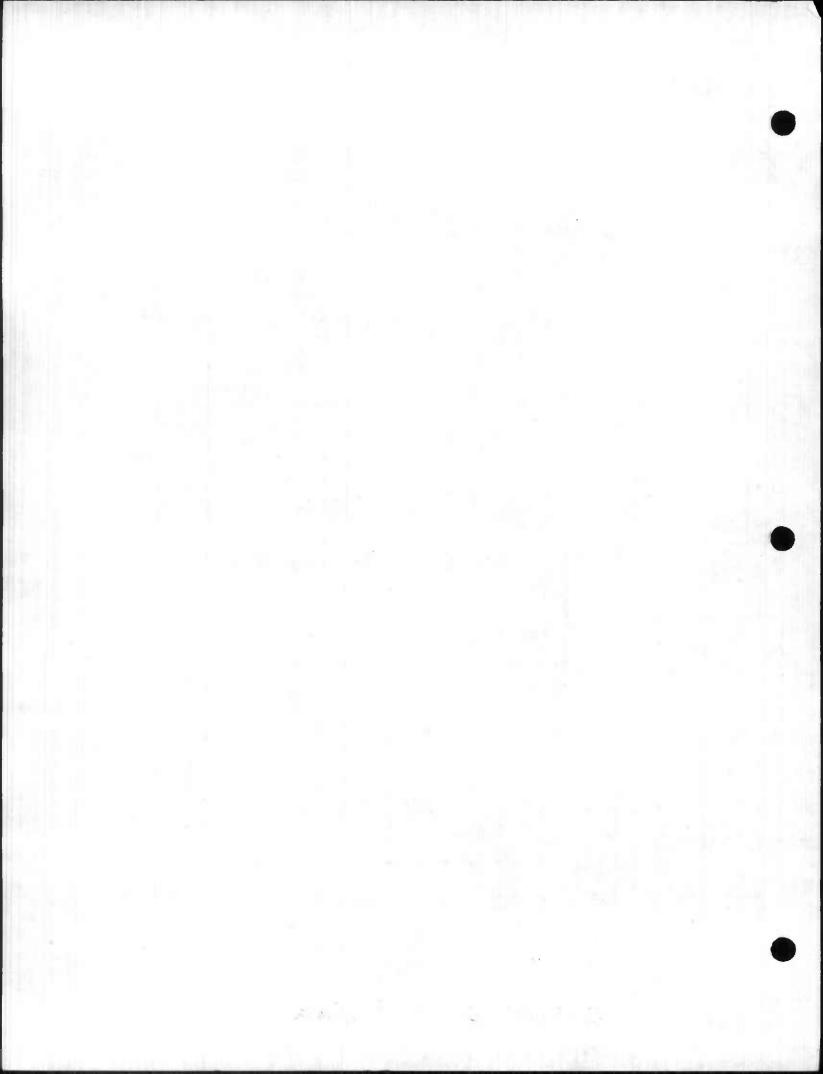
1 ertifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 12

Jeffrey Briggs, cause of death (Item 23a) (Type, Pript) Crot ton

31. Date filed (Month, Dey, Year)

32. Registrags Signature FEB



e of Maryland / Department of Health and Me	ental Hygiene	01.73	
Certificate of Death	Per No	0410	

Physi /Me Exan

Funera Directo

pernit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hyglene. Important: if Item 27 Is merked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic avant, the Medical Exercise must be notified at once.

Physician

Baitimore, Maryland 21215-0020

Examine Division of Vital Records, P.O. Box 68760,

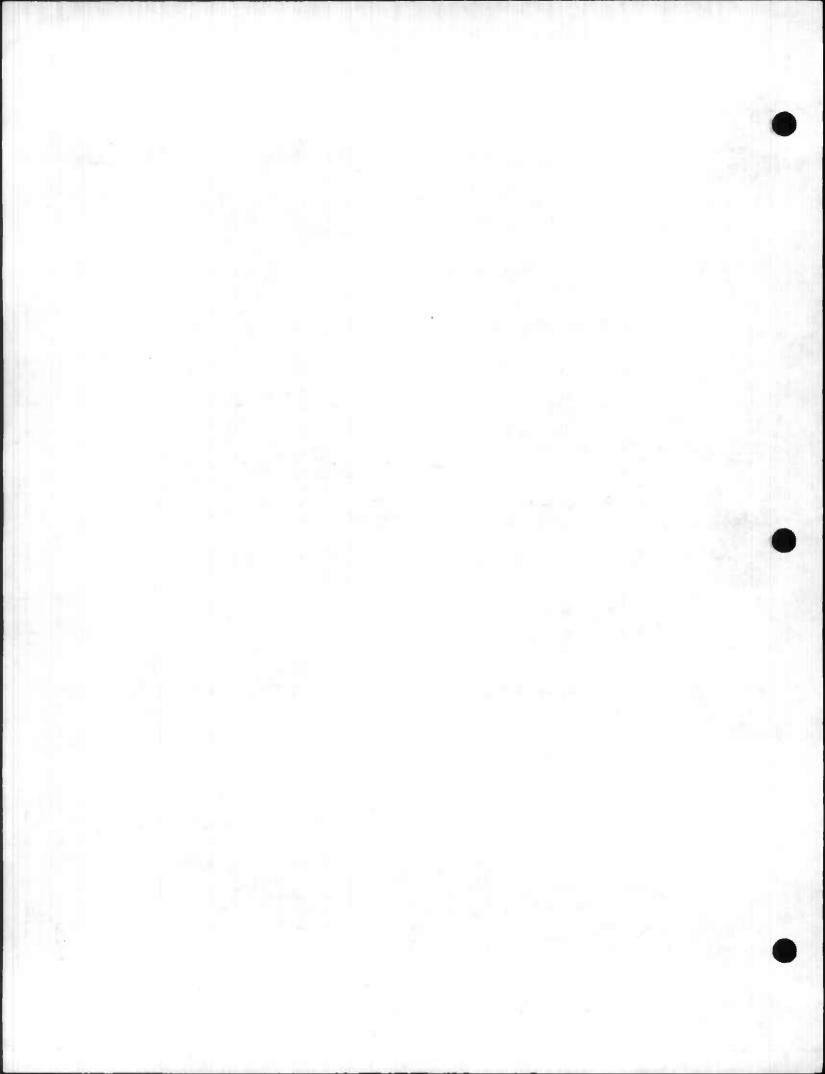
/Medica

To the Hospital or Attanding Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Nam	e (First, Middle	e, Last)							2. Date of Do Month	eath Dev	Ye	200	3. Time of Dea
Diane	I. Pars	sley							Februa				10:14
la Facility Name (i	If not institution	n, give street and nu	ım <i>ber)</i>			4	b. City, To	wn, or L	ocation of Deal	th 4c. C	County of D)eath	
Northwe	st Hosp	pital Cen	ter				Rand	al.1.s	town	E	Balti	mor	e
Social Security N 212-48-3	lumber	6. Sex	7. Age (In y	rs. last birthday		er 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth	9.	Birthpl	lace (State or For
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3 Widowed	4 Divorced	If Yes, Gi Year or D			1 ☐ Yes	2 NO	Specify:			S	Specify:	Whi	te
	15. Decedent			16a. Dece	edent's Usi	uat Occup	ation			16b. Kind	d of Busine	ess/Ind	lustry
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Elomontal y/ Seco	HIGELY (U-12)	5+	1-401 54)	Cas	e Exa	mine:	r				inist		
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Homer Pa	rslev ((Father)		7.0					atonsv			212	
Oe. Method of Disp			20t	. Plece of Disp	osition (Na	ame of		1	Dete		ation - City		
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21. Signeture of Fu	neral Service L	Licensee	1	2	22. Name e	and Addres	SS OF FACILI	Wi	tzke Fu	neral	Home	es.	Inc.
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Registrar



State of Maryland / Department of Health and Mental Hygiene

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Mary Schroeder / daughter 20a. Method of Disposition (Name of CR Burist 2 Chrometon, cremetory or other places) All Donation S Chine (Specify) 21. Signature of Funeral Service Licensee All Memorial Gardens 2/16/2000 Belair MD 22. Name Address of Fieldly Connell Jy Funeral Home of Essex 300. Mace AVe. Baltimore Md. 21221 23a. Part Enter the disease, or complications that caused the death. Dy not-entire the mode of giving, such as cardiac or respiratory arrest. Approximate Conselland		Charle	es A Buc	k				Martha	Happel		
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Sequentially list conditions or countries or solid part Sequence of	Mary Schro	oeder /	daughter			5 Glider	Drive B	altimore	MD 2	21220	
Connelly Funeral Home of Essex 30.0 Mace AVe. Balttimore Md. 21221 23s. Part: Enter the disease, or completations that caused the death. Displaying the mode of dying, such as cardiac or respiratory arrest. Approximate intraval Between Constitutions are conditions as a consequence of the mode of dying, such as cardiac or respiratory arrest. Approximate Intraval Between Constitutions are conditions, leading in death) Bue to (or as a consequence of): LUNC CANCER (DON - SNALL CELL) Due to (or as a consequence of): C. HRONG OBSTUCTIVE LUNG DISRASE Due to (or as a consequence of): C. HRONG OBSTUCTIVE LUNG DISRASE 24b. Were an autopsy performed? 25b. Were case referred to medical available prior to completion of case and search of case of the consequence of the case of the consequence of the cons	1 Burial 2 □ Cr	emetion 3 Re	emoval from State	CE	metery, cren	netory or other pla					
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Askammer? Second		o medical					26. Place of Dee	eth (Check only o	ne)		
27. Manper of Death 1 Neturat 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 38d.	1/	Ho	spital:	ent 2 E	R/Outpatien	3□ DOA O	hor			r (Specify)	5
3 Suicide 4 Homicide 28e. Place of Injury - At home, term, street, fectory, office 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of one of the cause (s) and manner stated. 29b. Signature and title of one of the cause (s) and manner stated. 29c. License number 29d. Dete signed (Month, Day, Year)	1 Neturat 5		28a. Date of Inju	iry	28b. Time of	28c. Inju	ry at rk?	T			
Check only one 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29b. Signature and little of output 29d. Dete signed (Month, Day, Year) 29d. Dete signed (Month, Day, Year) 29d. Detection 29d		Could not be determined	28e. Place of in building, et	jury - At hor c. (Specify)	ne, lerm, str	et, fectory, office				er of Rural F	Route Number,
DO055010 FEBRUARY 13, 2	(Check only 2	Certifying Physic Medical Examine	er: On the basis of	f axamination	rledge, death on and/or inv	occurred at the t estigation, in my	me, date and place opinion, deeth occu	, end due to the orred at the time,	cause(s) end mar dete and plece, a	nner as state nd dua to th	ed. ne cause(s)
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31 Date filed (Month Day Year) 32 Benietrar's Signature	- 1				23a) (Type, I			6 DO	BAITA	, no	2113
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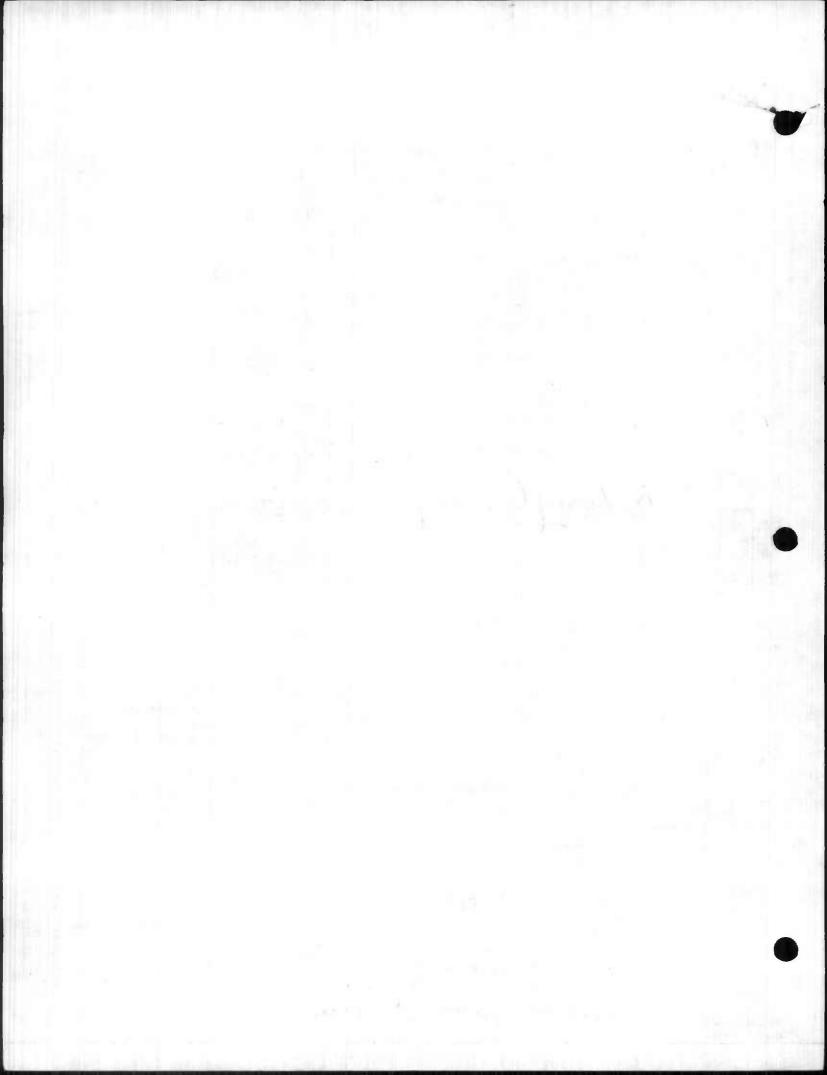
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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 ahould be filed within 72 hours after Department of Health and Mental Hydiene.

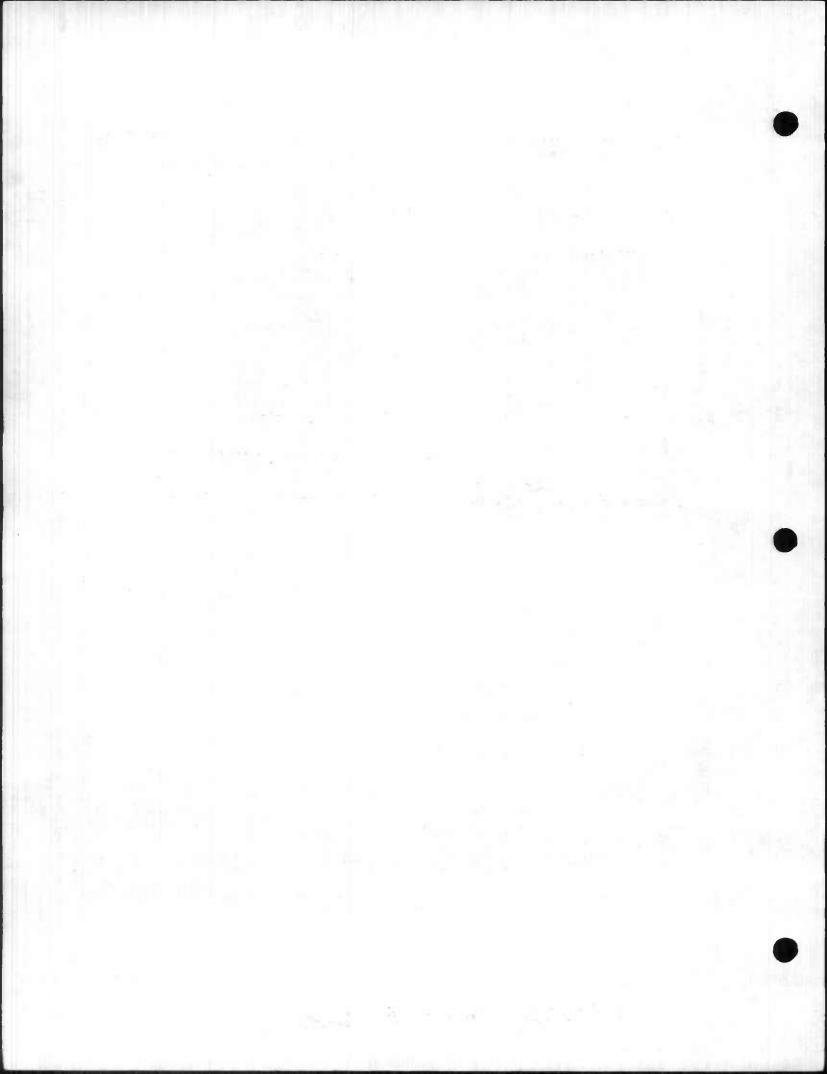
Phy /M Exa

To the Mospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death. Division of Vital Records, P.O. Box 68760,



		State of	Marylan		artmeni rtificate			and M	ental Hyg	iene	01	739	
	1. Decedent's Nama (First, Mi	ddle, Last)							2. Data of Deat	h	V	3. Time of Death	
hysician /Medical	Hazel Jean	ette Rohde						F	ebruary	15, 2	000	4:30AM	
niner	4a Facility Name (If not institu		cation of Death	4c. County									
Ш	Future Care	-					Reist			Bal	timor		
	5. Social Security Number 214-18-2752 Usual Residence of Decedent	6. Sex 1 □ M 20X F	7. Age (In yrs. I	78 Yrs.	Il Under Months	Days			8. Data of Birth (Month, Day, Sept.5,	1921	9. Birthe	place (State or Foreign http://	
	10a. State 10b. Cou	nty	10c. City	, Town or L	ocation						1	Od. Inside City Limits	
DIE BOILD	MD C	arroll		Westm:	inster							1 Yes Z No	
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	14 Hillside	Court				21	157			USA			
Completed by Funeral Director	11. Marital Status 1 Never Married 2 N 3 Widowed 4 Nover	Armed Formal 1 Yas :	2. Was Decedent Ever in U,S. Armed Forces? 1 □ Yas 2 ② No If Yes, Giva Year or Dates; 13. V If 13. V If 14. V If 15. V If 15. V If 16. V If 16. V If 17. V If 17. V If 18. V I				lispanic Ori an, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		ck, Whita,		
	15. Dece	lent'a Education hest grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	l Occup	ation	of working	200	16b. Kind of B	usiness/In	dustry	
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Be Con	12	No. 5 and		Hou	usewif	е	40.04.0	de Miller	(Cina 88'48' *		Home	2	
	17. Father's Name (First, Midd							a Mae	(First, Middle, N	raiden Suman	ne)		
	Vernon Abbot			10h Maii	an Addensa	/Ctan at			l Routa Number,	City of Tour	Chata 7in	Codel	
	Ted Rohde	So:	n						erstown,		1136	Code)	
ŀ	20a. Method of Disposition		20b. P	lace of Dispo	osition (Nam	na of				20c. Location -	City or To	own, Stata	
l	1 Burial 2 Crematic	n 3 Removal from S		ematery, cre				d 2	/17/00	Finksh	ura.	MD	
	21. Signature to Funeral Servi		LVE		2. Nama an								
	1 ac	50	ul		Eline					own Rd D 21136			
Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6	Due to (or as a consequence of): Due to (or as a consequence of): Dua to (or as a consequence of):										
	Part II. Other significant cond	itions contributing to dea	ith but not resu	altino in the u	nderlying ca	ausa oiv	en in Part I	23b. Did tobacco use contribute to the cause of					
	ATRIAL	Fishle f	m							98 21 No		bebly 4 Unknown	
	Preum	me							24a. Was a		av	ere autopsy findings railable prior to empletion of cause death?	
l									1 Yes 2 No 1 Yes 2				
l	25. Was case refarred to med						26. Place	of Death	(Check only on	Θ)			
-	examiner? 1 Yes 2 No	Hospital: 1 □ In	patient 2	ER/Outpatie	nt 3 DO	A Oth	er: 48 Nu	rsing Hon	ne 5 Reside	nce 6 Ott	ner (Speci	(y)	
	3 Suicide 6 Cou	stigation Id not be 28e. Place (, Day Year)	ury 28b. Tima of 28c. Injury at Work? Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No						reet and Numb , State)		al Routa Number,	
	29a. Certifier 1 Certific (Check only one)	ying Physician: To the basel Examiner: On the basel and manner	sis of axaminat	wledge, deat ion and/or in	h occurred a vastigation,	at the tir in my o	na, data an pinion, dea	d place, a th occurre	and dua to the ca ad at the time, da	nuse(s) and mi ite and place,	anner as s and due t	stated. the cause(s)	
	29b. Signature and title of cert	0					e number		2	9d. Data signe	d (Month,	Day, Year)	
	M Jado) 4	0867		1	2/1	2/00					
	30. Name and address of pers	NINVOCAZ		23a) (Type,	Print)	LE E	~ 7	ret	Rd	SA	1170	40 2120	
	31. Date filed (Month, Day, Ye FEB]	5 2000 32. Re	gistrar's Signat	tura	9 1	ha	1/2/						

ORIGINAL



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death Examiner **Funeral** Days Hours 1 M 2 F Director 28/19 Hary/An Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Boltinor Tas 2 No Directo Mary Anso 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21216 Herns 23e AUGNUE USA 2728 Funeral 12. Was Decedenf Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Reca - American indian, Black, Whife, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Black Specify. by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within nursing Home then Elemantary/Secondary (0-12) College (1-4or 5+) LUISES AIDE 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mantal Pages 1 and 2 should be BOYD MAE William PEARSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 16 19a. Informant's Name/Relationship (Type, Print) Department of Health an important: If them 27 is Bolts Mite, Maryland 2728 Riggs Avenue Mas HEARSON moiller 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial Cremetion 3 Removal from State 20 BALTIMORE, Mary low 4 ☐ Donation 5 ☐ Other (Specify) Cernetery 22. Name end Address of Facility CHATMAN - HARRIS FINE ON LIONE 21. Signeture of Funerel Service Licensee REISTERSTOUN REMO 5240 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each lina. Approximete Interval Betwaer Onset and Death Physician Immediete Cause (Final disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Be Completed 24e. Was an autopsy 1 Tyes 1 ☐ Yes 2 ☐ No 2 No 25. Was case raferred to medical 26. Place of Death (Chack only ona) Othar: Nursing Home No No 1 Inpatient edical Certification: To 1 Yes 3□ DOA 2 ER/Outpatient 5 ☐ Residence 8 ☐ Other (Specify) this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. To the Hospital or Attending Physician: death. Director: A within 24 hours aft To the Funeral Dic completely filled in

State Registrar 4 Homicide

29a. Certifier

29b. Signature at

29c. License number

29d. Dete signed (Month, Day, Year)

and address of person who complated cause of death (Itam 23a) (Type, Print) DREMS RD BAL MAZIZE

2000 Registrer's Signature

nd title of certifier

Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Beatrice **Physician** Kothenhoeter Josephine 9:45 PM 2000 Feb /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPI BALT: If Under 24 Hrs. TAL IMORE If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Months Days Hours 1□M 20 F 212 Yrs. Director **Usual Residence of Decedent** 10a. State 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at ATONSUITE MD BALTIMORE Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 91328 EDMONDSON U.S. A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status flied within 72 hours after 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give 'Year or Dates: Specify: WHITE þ 3 (Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Uwn Homemalee 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be nent of Heelth end Mentel MARGARE le marked SCHMI 2 19a. Informant's Narpe/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 Exmondson Dre permit. Peges 1 and 2 Department of Heelth el Important: If Itam 27 ie any Injury or other tracents. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State BAUTIMORE, MD 12-14-00 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WITZKE FUNCYOU Home Inc 21. Signature of Funeral Service Licenses Edmondson are Catorsulle, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Week neumonia disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner sician and burief-transit the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buriel 68760 Physician/Medical Due to (or es a consequence of): 080 P.O. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tohecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2D No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) a Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of After Division 5 Pending 1 X Natural deeth. investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 Homicide ò To the Hospital within 24 hours To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the odical 29a. Certifier niner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Maulane, MD 046704 2000 ~ra

State

Registrar

31. Date filed (Month, Day, Year) 1 5 2000 FEB

MUTOMBO

KAN KONDE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL

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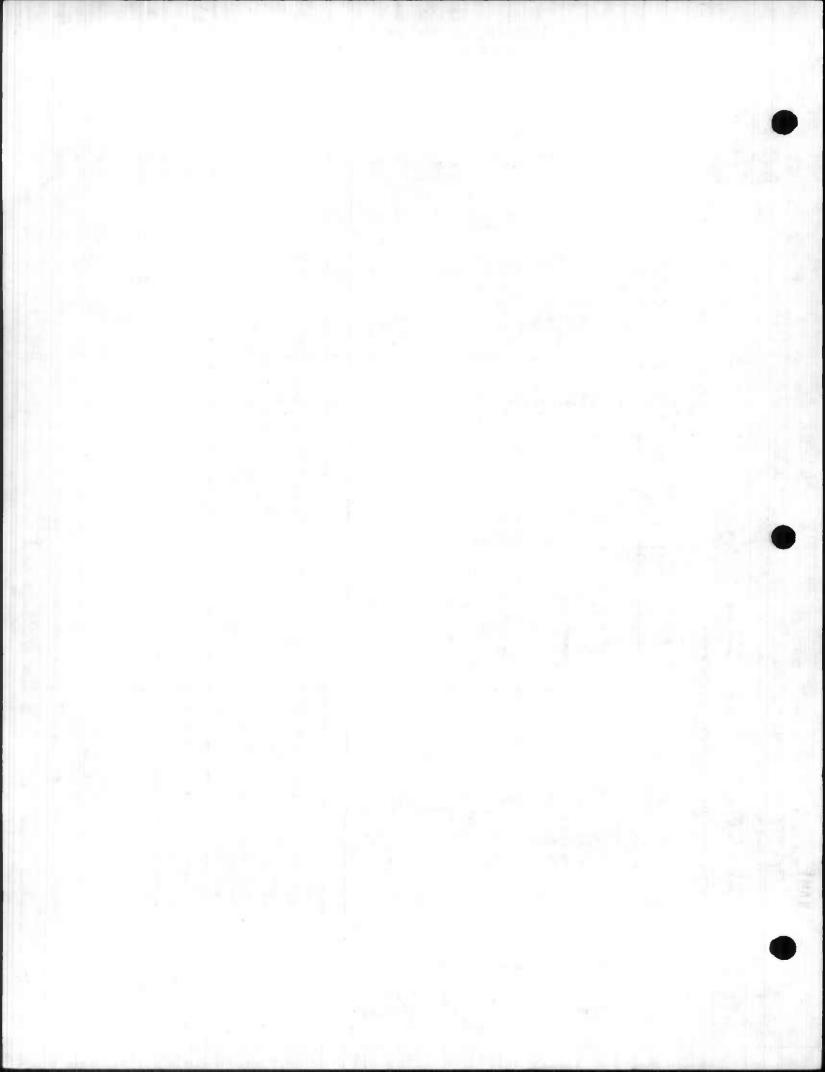
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NAME



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** February 13, 2000 7:00am Cesario Raspi Caesar /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 228 South Oldham Street If Linder 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Italy **Funeral** Days Hours 1 X M 2 □ F Months 93 213-07-8338 Director Usual Residence of Decedent 10a State 10b County 10c, City, Town or Location 10d. Inside City Limits show n/a Baltimore 1⊠ Yes 2 No Director 25a-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Berrie 23s or 21224 TISA 228 South Oldham Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Merried ☐ Yes 2 No 8 Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 🖾 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced 'natural' Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiens. ther then Elementery/Secondary (0-12) College (1-4or 5+) City of Baltimore Department of Public Works 6th permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important; if fleen \$7 is marked other any injury or other tre. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 88 Luigi Raspi Pasquala D'Julio 19a. Informant's Name/Reletionship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnna Machniak 948 Kayden Lane, Baltimore, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other placa) 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 2/17/2000 Baltimore, Maryland Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Joseph N. Zannino Jr. Funeral Home 263 South Conkling Street, Baltimore, Maryland 21224 Zunnino area 23a. Part1. Enter the disease, or cemplications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician ATHEROSCIAROTTE CALBIOVASCULAL DISTANT /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner attending physician and for use as the burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequenca of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 12 Yes 2 No 3 Probably 4 Unknown Records, þ requires 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy peen completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical axaminet?

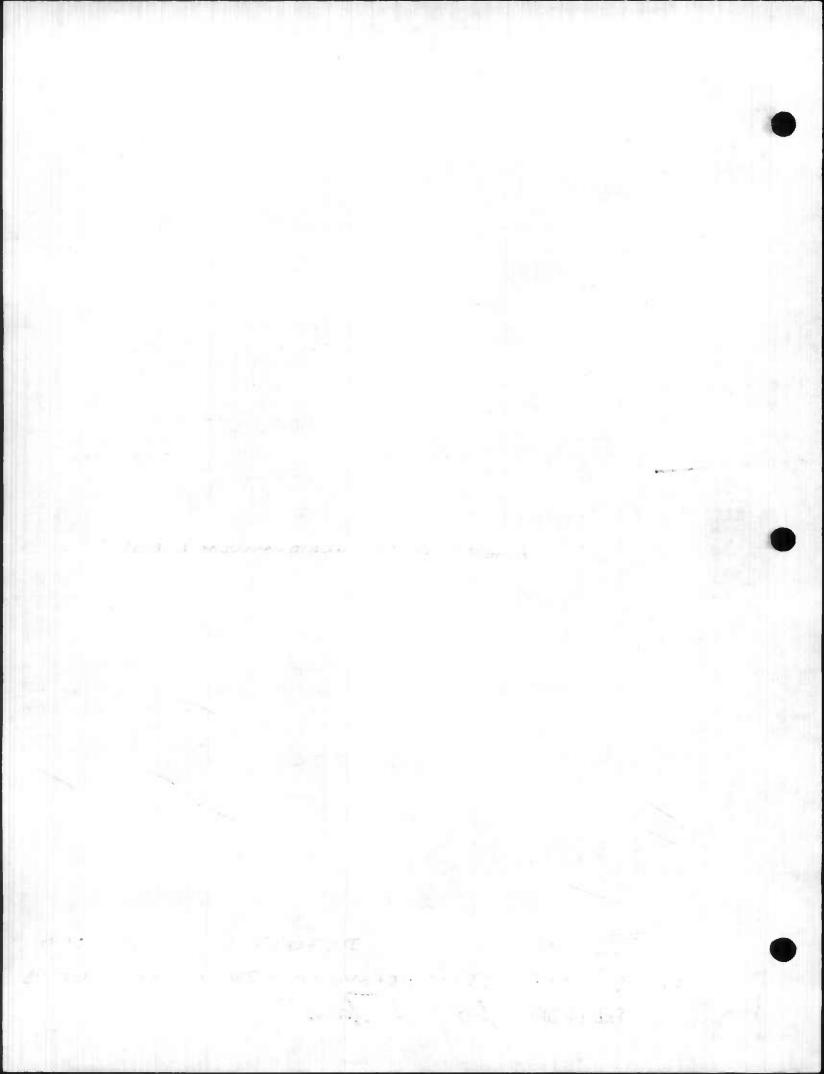
Yes 2 No 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 2 Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37089 2000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRUCE LEFE 5505 HOPKINS BAYVIEW CR. BACTIMORF MS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

FEB 15



			1. Decedant's Name	- /Pi	41		С	ertificate	of Deati			. No.	, ,	70		
	Physic /Medi		JOSEPH SWINDER							R Feb	ta of Death onth	Day th	2000	3. Tima of Death		
	Exami	ner	The second secon	f not Institution, gi			A 1			Town, or Location		4c. County	of Death	C		
Н	Funerai		5. Social Sacurity N	umber 6.	Sax		rs. last birthda	y) If Under 1	Year If Unda			-				
	Director		215-14-0	430	№ M 2□ F		76 Yrs.	Months	Days Hours	Min. May	rs. 8. Deta of Birth (Month, Day, Year) May 25 1923 Baltimor					
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	th with th	ai Director	10e. Street and Num 9 E1kh	_{nber} art Cour	t			10f. Zip C	oda 1237		10g	. Citizen of USA	What Country	?		
020	F # 5 1	by Funeral	11. Marital Status 1 Nevar Marri 3 Widowed	ed 2 Married	12. Was Dac Armed Fo 1X Yas If Yes, Gi Yaar or D	rcas? 2 ∐ No /e	U,S. 1:	3. Was Daceda If Yas, specifi		Origin? (Specify Ya an, Puarto Rican, y:	as or No- atc.)		ca - Amarican ck, Whita, atc. y: Whit			
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			Virgini	Virginia Swinder / wife 9 Elkhart Court Balt									237			
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Division	ttendin death. rtor: Aft r tha fur	Certification:	1 X Natural 2 ☐ Accidant 3 ☐ Suicida	5 Panding invastigatio	on Month, Day Year) Injury Work? 1 Yas 2 No								eet and Number or Rural Routa Number,			
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	Hospital or 24 hours efter Funeral Dir lately filled in	dical	29a. Cartifiar (Check only one)	1X Certifying Ph 2☐ Medical Exar	niner: On tha bi	best of my ki asis of axami ar statad.	nowledge, da netion and/or	ath occurred at Invastigation, Ir	tha time, date e my opinion, da	end place, and due tath occurred at the	laca, and dua to tha causa(s) end mannar as stated. cocurrad at tha tima, data and place, and dua to tha causa(s)					

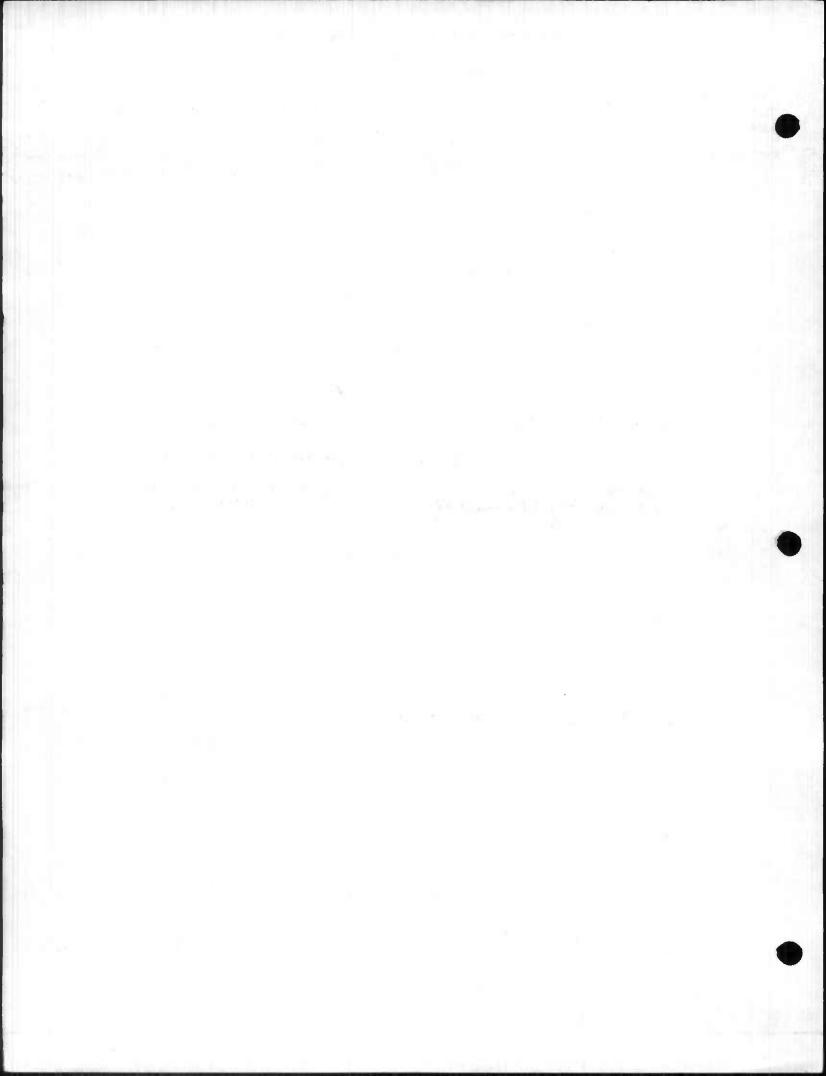
State Registrar

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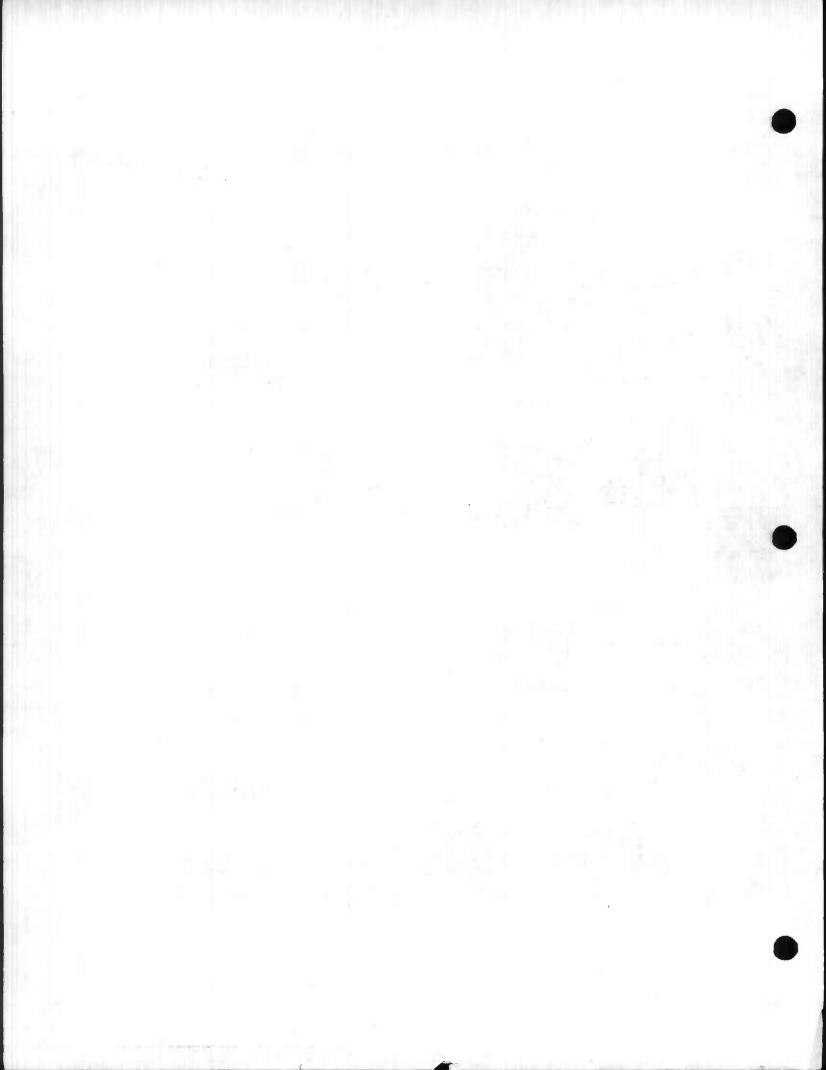
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ion who completed cause of deeth (Item 23a) (Type, Print) 1737 WAVERLY WAY, APTC BALTIMORE, MD 21239 32. Registrar's Signatura

29c. Licansa number P 13456 29d. Data signed (Month, Day, Year)

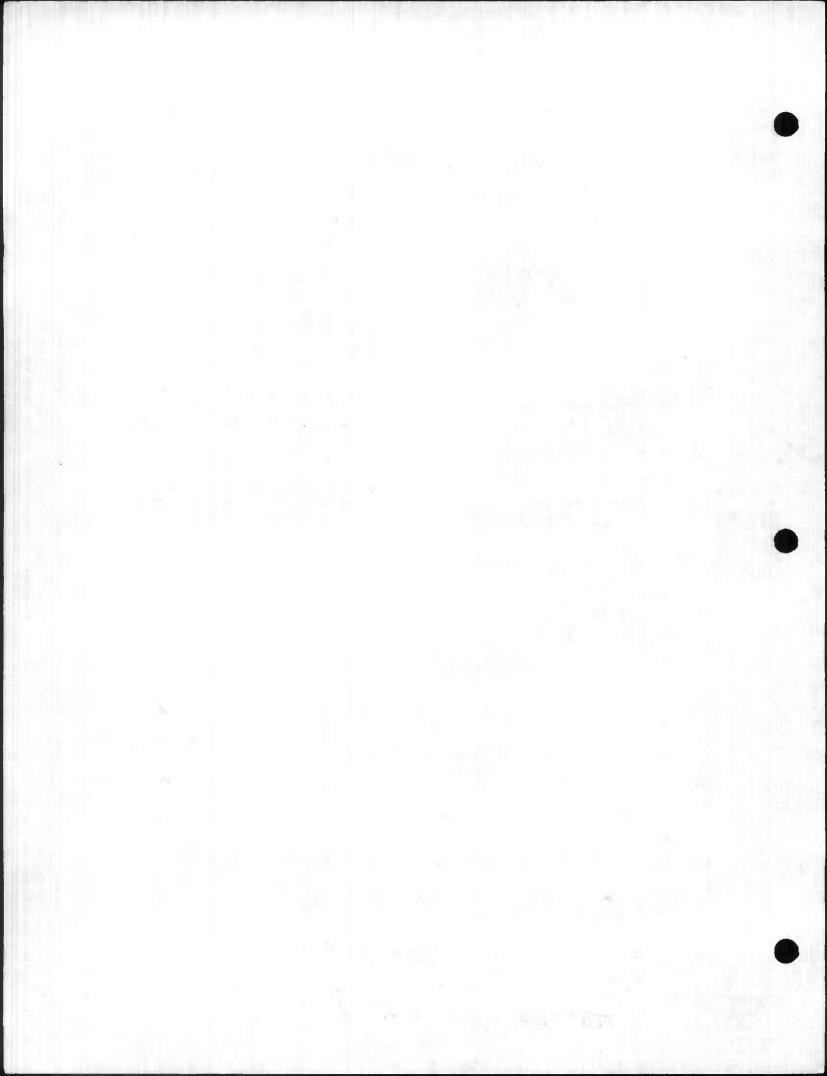


DHMH 16 Rev 6/95



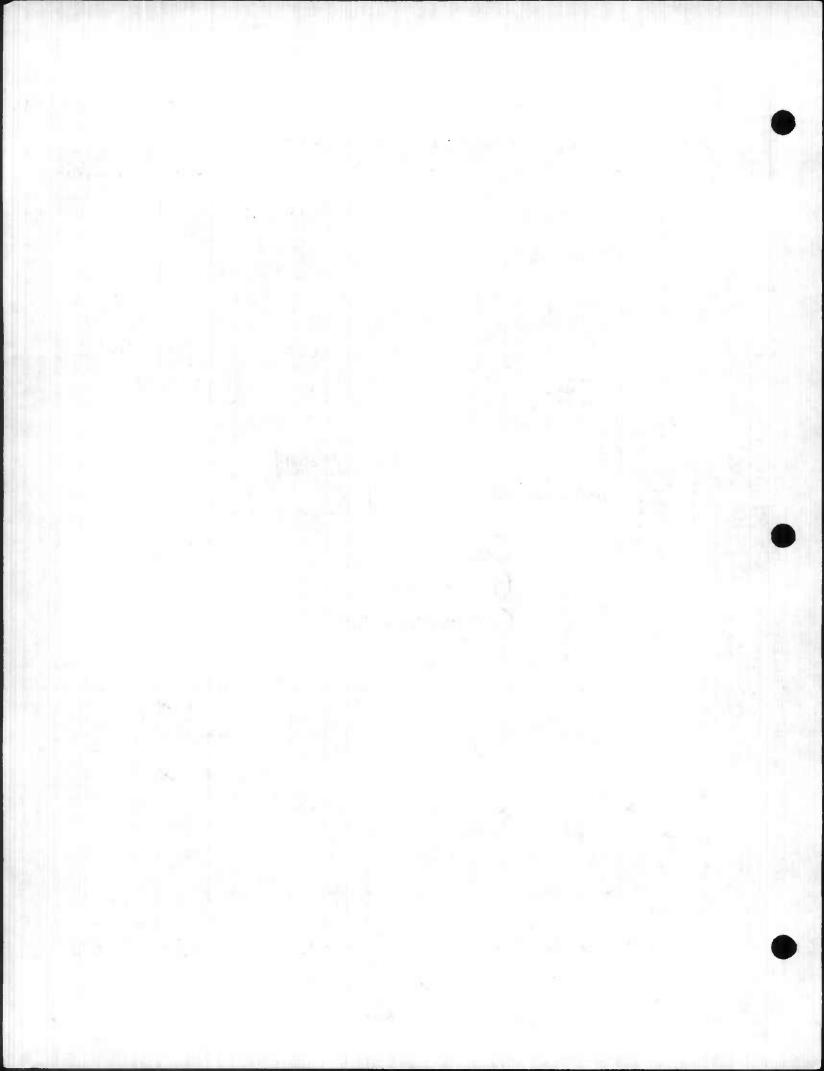
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedenl'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 12, Margaret Mary Svehla 2000 6:05 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 💢 F 84 Yrs 218-09-0936 Director Maryland March 30, 1915 Usual Residence of Decedent r 28a-f show r notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itsms 23s or must be 21236 U.S.A. 4224 Penn Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ğ 1 Never Married 2 Married altimore. Maryland 21215-0020 specify: White 1 Yas 2 No Specify: À 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Homemaker Own Home Department of Health and Mental Hy (Important) if Theory or other traumatic event, 9005s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Thomas Mary Agnes Gannon John 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Joseph F. Svehla 4224 Penn Avenue, Baltimore, MD 21236 (son) 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20a. Method ol Disposition Date 20c. Location - City or Town, Stata 1 Ø Buriat 2 ☐ Cremation 3 ☐ Removal Irom State Most Holy Redeemer Cem. 4 ☐ Donation 5 ☐ Other (Specify) 12/16/00 Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mays 9705 Belair Rd., Baltimore, MD 21236 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immedias cause. Enter Underlying Cause (Disease or injury that initiated event Dua to (or as a consequence of): Box 68760 that the death certificate be Physician/Medical that initiated events resulting in death) Last 2 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. E 1 Yea 2 No 3 Probably 4 Unknown ğ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? ate has page 2 s 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital 88 25. Was case referred to medical examiner? 26. Piaca of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 914 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Albar 1 DiNatural 5 Pending investigation Attending in 24 hours after death w Funeral Director: A yealy filled in h deeth. 1 Yes 2 No 2 Accident 6 Could not be 281. Localion (Street end Number or Rurel Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, atc. (Specify) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the P within 2 To the F 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2-14-60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8731BEIRE PD, BAUTO MB 36 -GAMBOR MA 1. Data liled (Month, Day, 32. Registrar Signature State Deneva

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** :18 AM eb 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITOI Olumbia xard County General If Under 24 Hrs. 8. 5. Social Security Number Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Quintry) 1 M 20 F **Funeral** Days 055-52-1215 reginia Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow idical Examiner must be notified at 1 Yas 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Funeral 14. Race Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 ☐ Married ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0020 1□ Yes 2 No Black Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own memakee 9 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hicks la merked 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11691 14-15 Mott Ave., New York, N.Y. Department of Health a Important: If item 27 le any Injury or other tra 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from Stata rematory 4 Donation 5 Other (Specify) 2/11/00 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Witzke Funeral Inc. Home 5555 Twin Knolls Rd., Columbia, respected Md. 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximata Intarval Between Onset and Death Physician /Medical Immediate Causa (Final P575 disaase or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner UMONIA or Attending Physicien: The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Teomye Physician/Medical Due to (or as a consequence of) signed by the ettending p P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? should page 2 s has 2 No 1 Yas 2 No certificate funeral director, Be 25. Was case rafarred to medical axaminer?
1 Yas No 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA edical Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Affer 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be detarmined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the \$ a 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 0 complated cause of death (Item 23a) (Type, Print) COLUMBIA reekman KNOLL al 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 2000 B Registrar

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Defe of Death February 1, 200-Year → Month **Physician** 2:30A.M Robert John Simpson 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner Baltimore osedala tranklindquare 4 enter OSPITAL If Under 24 Hrs. 8. Defe of Birth (Month, Day, Year) If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1X M 2□ F Yrs. 212-62-7968 **Director** 46 Oct. 22, 1953 Baltimore, Maryland Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or flama 23a or 28a-f ahow The Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Kingsville 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 12405 Glen Bauer Road Funeral 21087 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Merifal Stetus Bleck, Whita, atc. filed within 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 🕅 No If Yes, Give Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Detes: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) ·mpson, Rober 12 yrs. Computer Programmer 6yrs. Computer Industry permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If Nem Z7 Is marked other
any Injury or other treasment 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John L. Simpson Anne Prostredny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Lauren F. Simpson (Wife) 12405 Glen Bauer Road Kingsville, MD. 21087 altimore. 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 2/10/2000 Baltimore, Maryland 22. Name end Address of Facility E.F.Lassahn Funeral Home 21. Signature of Funerel Service Licer 11750 Belair Road Kingsville, MD. 21087 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximete tritarval Between Onset end Deeth **Physician** /Medical Immediata Causa (Final . Metabolic Encephalopathy disease or condition resulting in deeth) Examiner Examiner Sclerosi Itiole or Attending Physician: The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Wara sutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificate funeral director. Be 25. Was case referred to medical 28. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28e. Deta of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Neturel 2 Accident he Hospital or Attending in 24 hours after death. The Funeral Director: After pletely filled in by the fun 1 Yas 2 No 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

Registrar

Michael

31. Date filed (Month, Dey, Year)

Drive Beltimore, MD2123"

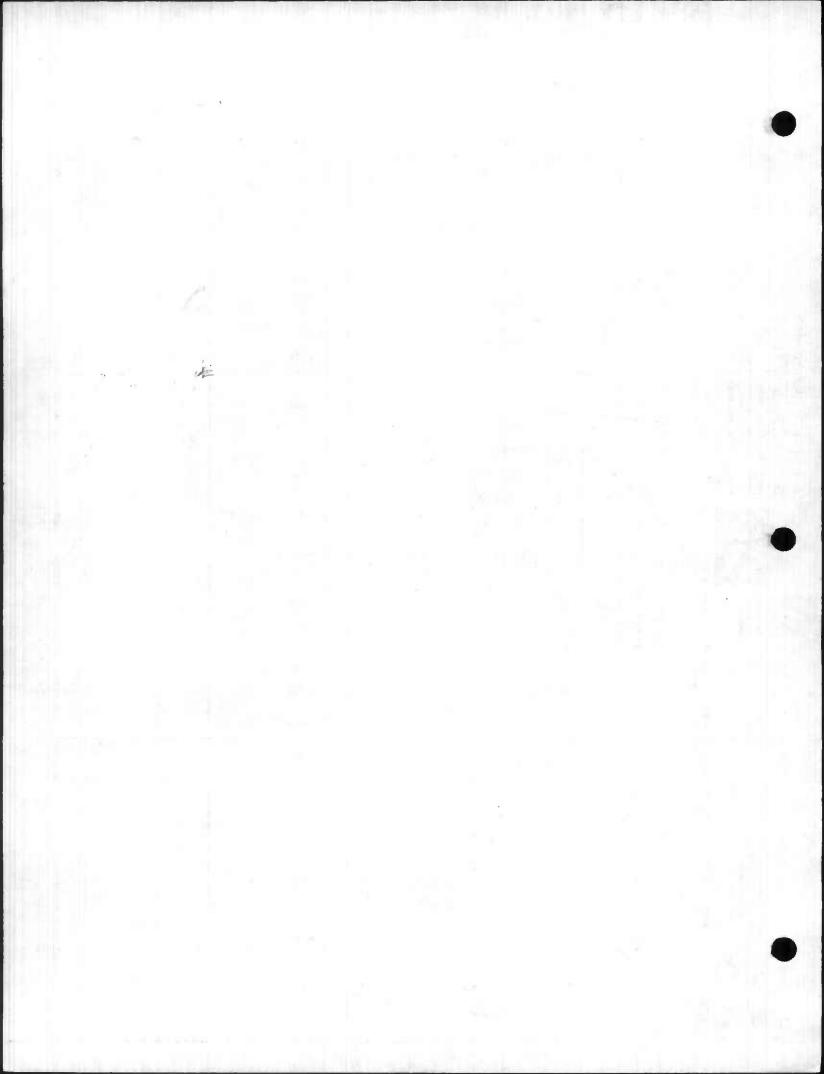
completed cause of death (ftem 23a) (Type, Print)

32. Register's Signature

2000

FEB 14

9000 Franklin Square.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3. Time of Deeth **Physician** Month James Milton Stoner Feb.8,2000 9:20AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 3320 Summit Avenue Baltimore Baltimore If Under 1 Year if Under 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number 6. Sex 1⊠ M 2□ F 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) Yrs 214-16-9194 Usuel Residence of Decedent July 7,1921 Brunswick Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3320 Summit 21234 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Yeer or Detes: 11. Meritel Stetus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 □ Divorced Specify: White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 10 yrs. n/a Machinist Western Electric 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William M. Stoner Nellie Bisset 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Chris Hash (Daughter) 3313 North Furnace Rd. Jarrettsville,MD.21084 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Krieders Church Cem. 2/11/00 Westminster, Maryland 22. Name end Address of Facility E.F.Lassahn Funeral Home 21. Signeture of Poheral Service Lice 11750 Belair Road Kingsville,MD.21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Ceuse (Final Adenoca chows diseese or condition resulting in death) Due to (or as a consequence of) Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Physician/Medicai Due to (or es e consequenca of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings eveileble prior to 24a. Was en autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

Box 68760. 8 signed by this certificate has been Ather after death Director:

Funeral

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Physician /Medical

Examiner

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page 2 should

Certification:

Hygiene.

Pages 1 and 2 should be facilities of Health and Mental I not: If Item 27 Is marked of

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

To the Hospital within 24 hours a To the Funeral D

Medicai 29b. Signature and title of cartifier

29a. Certifier

4 Homicide

Attending uno

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number 137016 29d. Dete signed (Month, Dey, Year)

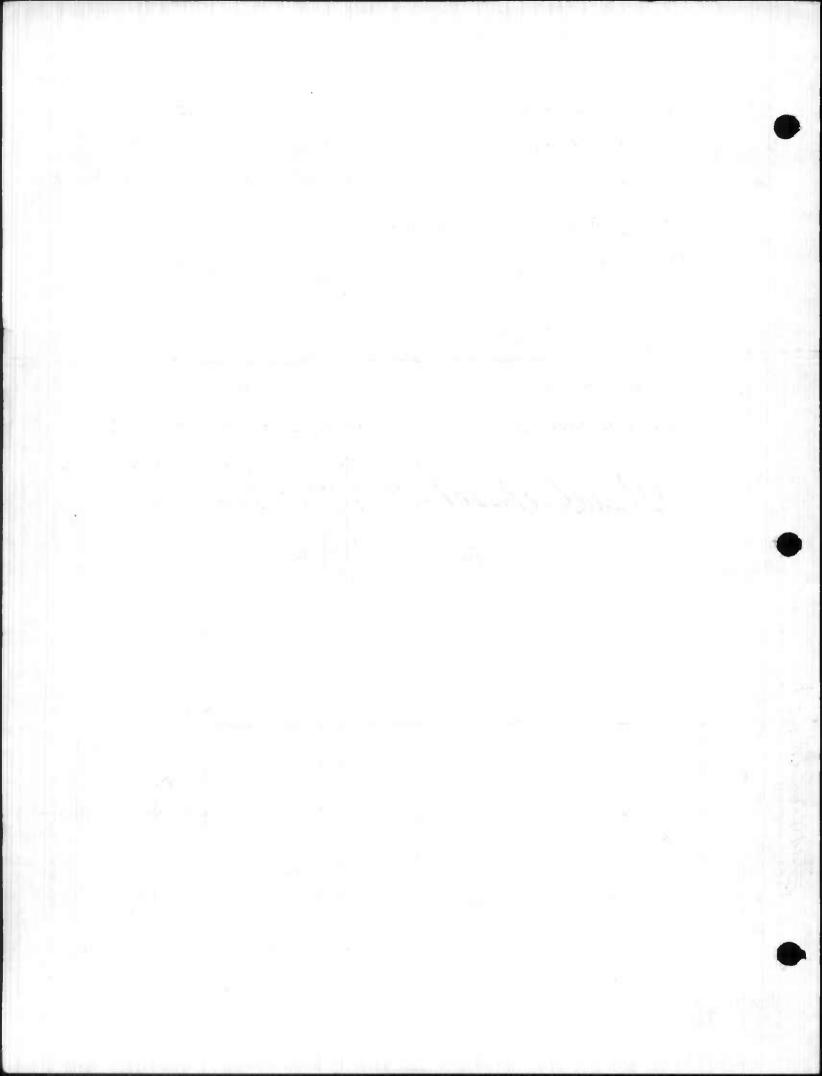
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Kennot M. Grew, 20

🎏 Certifying Phyelcien: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) end menner stated.

6701 N. Charles H., Sup 4105 Biltinou, and 21204

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

State Registrar 31. Dete filed (Month, Day, Yeer)
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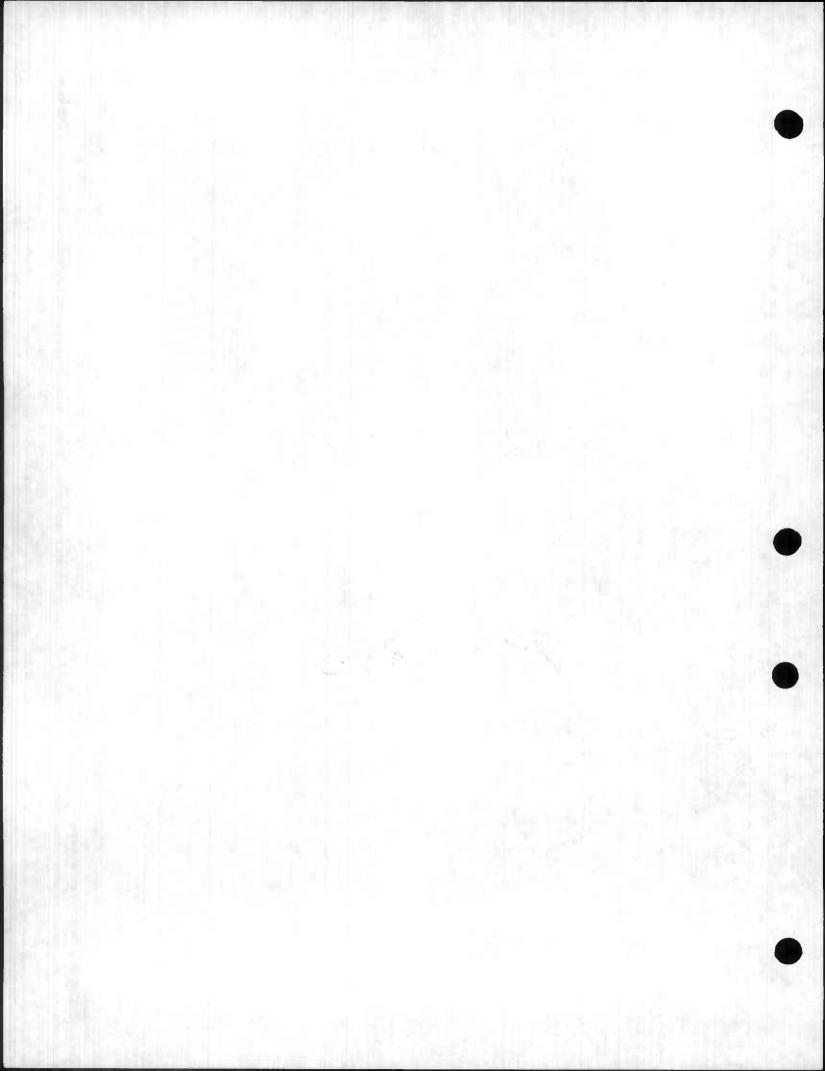
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year 4e Facility Name (If not institution, give street and number) Smith 4, 2000 4c. County of Deeth 2202 rebruggy 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Yrs. 96 January 12,1904 220-09-9329 MD Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits YYes 2 No Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 South Street 21750 TISA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 Carpenter Home Improvement 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Tom Smith Mary Smith 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13137 Brendan Wood Dr. Florissant, MO 63033 Stanley Smith/Son 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) St. Peter's Catholic 2/9/2000 Hancock, MD 22. Name and Address of Fecility Grove Funeral Home, P.A. 21. Signature of Funeral Service Licenses 141 W.Main St. Hancock, MD 21750-0368 that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, 23a. Pert1. Enter the disease, or complete shock, or heart feilure. List only one Approximate Interval Between Onset and Death Strute cerebovascular accident hours Immediate Cause (Final disease or condition resulting in deeth) week Neumont C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown eval 24b. Were autopsy findings available prior to 24e. Wes an eutopsy

Physician /Medical Examiner

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2 Accident

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4 Homicide

Completed Attending Physician: director Be Certification: To After death.

25. Wes case referred to medical 27. Mennes of Death To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b edical 29e, Certifier

State Registrar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. terrosclurație cardio-

Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year)

1 Yes ANO 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury et Work?

 Location (Street and Number or Rural Route Number, City or Town, State) 10 certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier M.D. 29c. License number

1 ☐ Yes 2 ☐ No

29d. Dete signed (Month, Day, Year) 5/2000

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

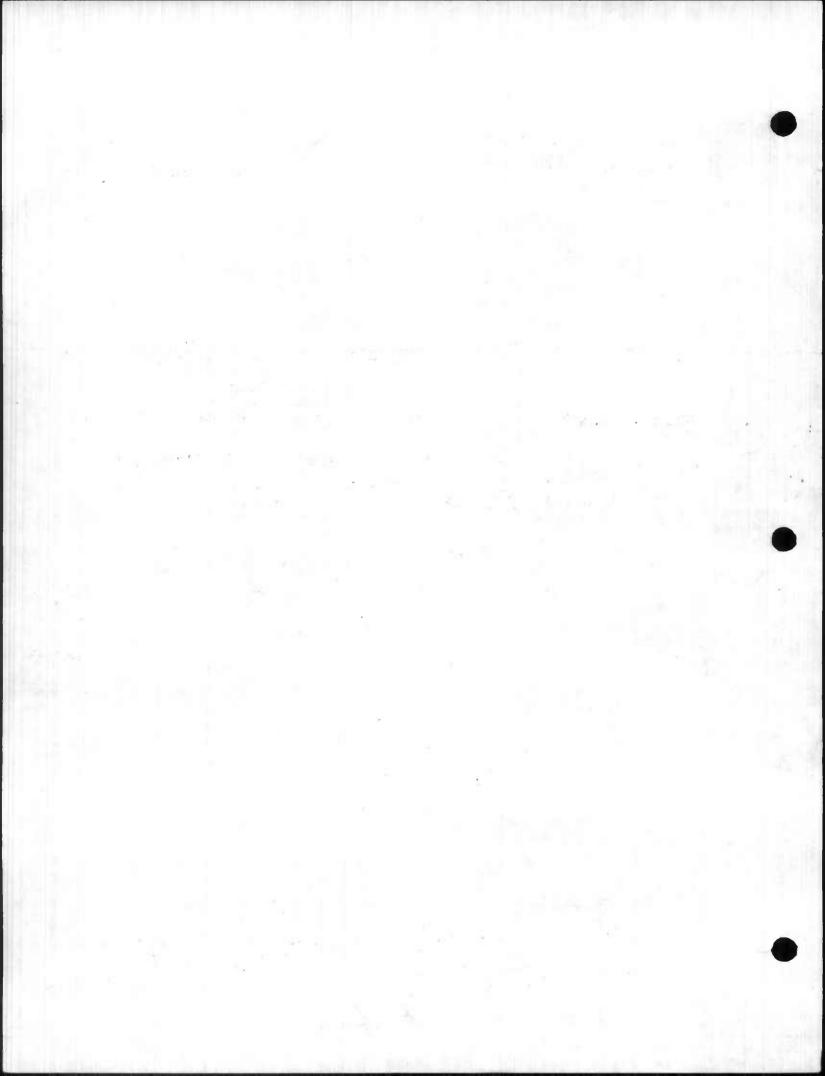
completed cause of death (Item 23a) (Type, Print) COPPLECE 31. Dete filed (Month, Dey, Year)

32. Registrar's Signeture

28b. Time of

28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify)

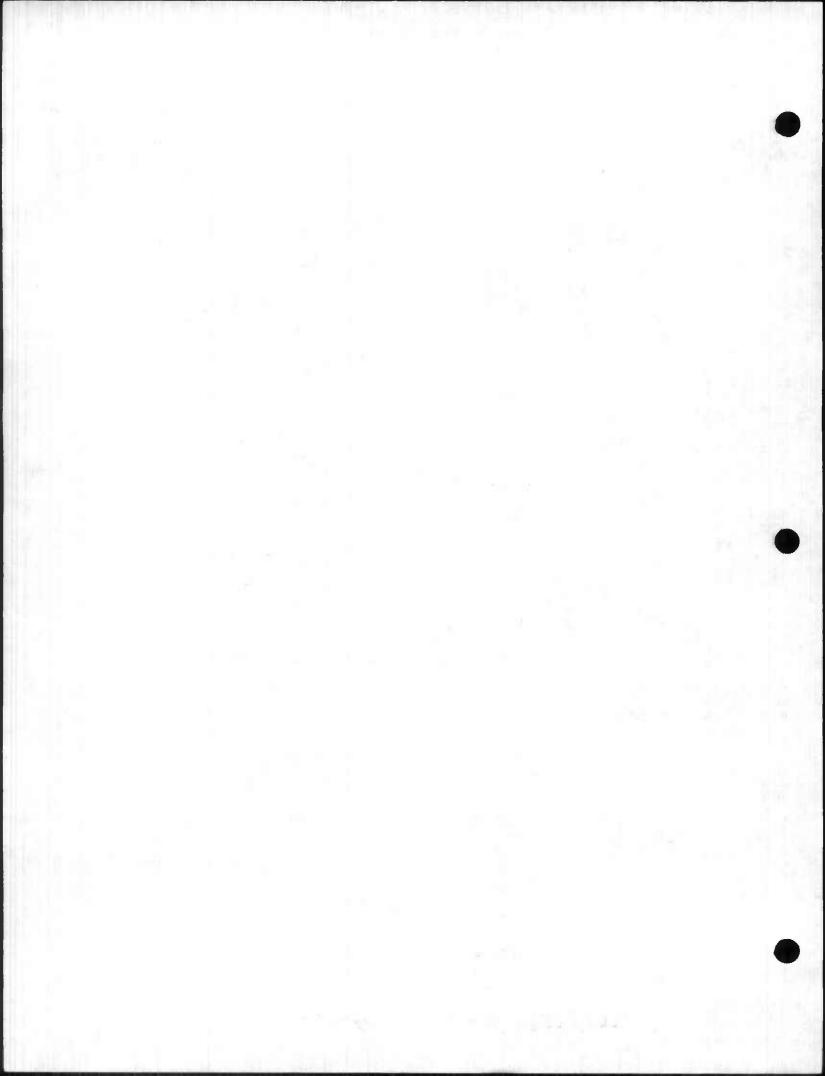
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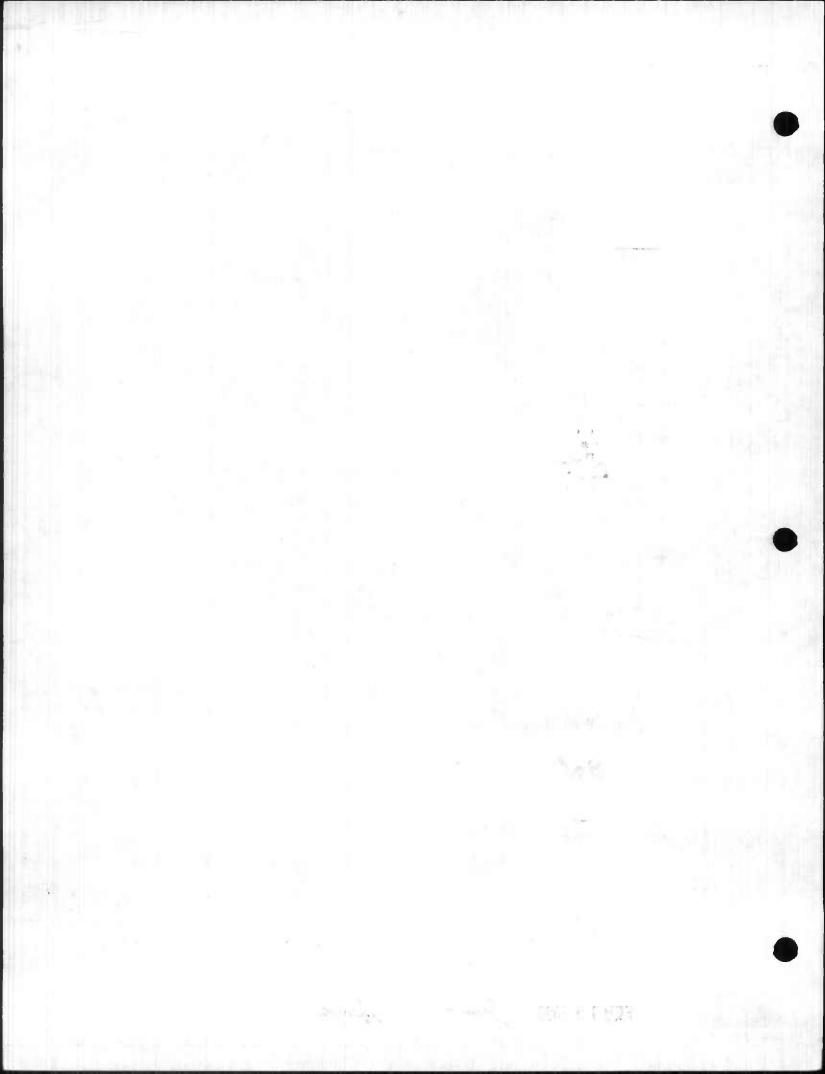
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زر	Examine	r f	e Facility Name (If not						1			cation of Death	4c. County				
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u	W T O -		Part II. Other significant	t conditions co	ntributing to death	but not resu	ulting in the	underlying o	euse giv	an in Part I		23b. Dld t	23b. Did tobacco use contributs to the cause of				
P.0	that the dea		Preus	nonia								101	rss 2 No	3 Pro	bably	4 Unknown	
ds,	tr se digneration	2									_	Ode Mee	on autonous	24h W	lara auto	opsy findings	
Records,		5											an autopsy med?	8/	/ailable p	prior to n of cause	
Rec	has pe 2											101	es 22 No		death?	2 No	
Vital	certificate rector, pag		25. Was case referred to	o medical						26 Place	of Deat	h (Check only o	•		162	2 140	
2	P 1.45	o	examiner? 1 ☐ Yes 2 X No	-	Hospitai: 1 ☐ Inpat	ient 2 🗆	ER/Outpatie	ent 3 DC	DA Oth	ner:		me 5 Resid		her (Speci	fy)		
Jo u	g Phy her this neral c		27. Manner of Death	Ponding	28a. Date of Inj (Month, D	ury av Year)	28b. Time	of 2	28c. Inju	y at		28d. Describe h	now injury occu	rred			
Sio	Attending or death. octor: After tune by the fune) all	2 Accident	Pending investigation				М		Yes 2□							
Division	al or Attending P is after death. al Director: After t ed in by the funer. Certification:		3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Ir building, e	njury - At ho tc. <i>(Specif</i>)	oma, farm, s	treet, factor	y, office			28f. Location (S City or Tox	Street and Number or Rural Route Number, wn, Stete)				
ļ	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in B Madding Certi				elclan: To the besi iner: On the basia and manners	of examinat										use(s)	
	ro the complete of the complet		29b. Signature end title	of certifier				29	c. Licens	e number			29d. Date signed (Month, Day, Year)				
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	0	;	00. Nama and address of	of person who o	ompleted cause of	death (Itam	23a) (Type	, Print)		Mill	0	ed Suite	00	uings 1	n.11s	MD	
			Nennet 31. Date filed (Month, D		Flick M	7 O rer's Signa	90	raint	ers	11/1/1	NUG	e Juise	126		2	1117	
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AMENDE	D ITEM #10e P	ER FH G780 27	15/2000 AF		of Marylar		artmei				Mental Hy	giene Reg. No.	00	01.	750	
,		1. Decedent's Name					7111104		20011		2. Data of De	eath	00		ime of Death	
	Physician /Medical	B	SAMUE					SOD	Y		Month FEBRUA	RY 11	., 2000		:30AM	
	Examiner	4a Facility Name (II			ımber)				4b. City, T	own, or L	ocation of Deat	h 4c. C	County of Dea	ath		
	26	2 POMONA					H Llade	r 1 Year	BALT	IMORE		BALTI				
	Funeral Director	5. Social Security No. 214-01-	1676	Sex 12∑M 2□F	7. Aga (In yrs. 92		Months		Hours		8. Data of Bi (Month, D. DEC • 2	ay, Year) 5, 19	07	Birthplaca (State or Fore Country) MD		
	pung as as	Usual Residence of 10s. State	10b. County		10c. Cit	ty, Town or L	ocation							10d. tns	ide City Limits	
	Mary H ah	MD	BALTI	MORE		BALT	IMORE							10	Yas 2 No	
	th with the Maryland 23a or 28a-f ahow ust be notified at	10e. Street and Num					10f. Zi	p Code				10g. Citiz	en of What C	ountry?		
	or death with the Maryle terms 23s or 28s-1 sho we must be notified at uneral Director	2 FOMONA	FEAST #:	302					2120	8		U	.S.A.			
		11. Merital Status 1 Never Marrie 3 Widowed	ed 2 💢 Married	Armed F	2 X No	l,S. 13.	Was Dece If Yas, spe 1 Yas				pecify Yes or No Rican, atc.)		I. Race - Am Bleck, Whi			
	72 hours at natural; or deal Earn		15. Decedent's E	ducation		16a. Dece	dent's Usu	el Occup	ation			16b. Kin	d of Businass	s/Industry		
		(Speci	ify only highest gr ndary (0-12)		(1-4or 5+)	(Giva	kind of wa DO NOT i	ork dona ise retired	during mo d)	st of worl	king					
	d 2121 filed within Hygiena. fiher than " ant, fre year			2		OPTIO	CIAN					-	PTICAL			
	Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Mantal Hyglena. 7 Is marked other twan 'natural', or traumatic evant, fre than 'natural'. To Be Completed by F	17. Father's Nema (First, Middla, Las	t)		SODY			DEEI		e (First, Middle	, Maiden S		TZNER	1	
	Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiena. Important: if Item 27 Is marked other than any injury or other traumatic event, the Mary injury or other traumatic event, the Market	19e. Informant's Na	me/Ralationship								ral Routa Numb					
	Ore, of Heam of Heam	20a. Mathod ot Disp	osition	Removel from		Plece of Disponentery, cre	osition (Na	ma of			Deta		ation - City o		ete	
	Saltimore, semit. Pages 1 ar separtment of Heal mportant: if hear my injury or other most.		5 Othar (Speci	(fy)		ZUK AN	MUNO 2 hama a	_	-		2/13/00	BAI	TIMOR	ORE, MD		
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	Physician /Medical Examiner	tmmediata Cause (I disaasa or condition rasulting In deeth)	Final 1	a	-	MON				*				Onset	t and Death	
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	P.O. BOX 58/60 at the death certificate be tby the attending physicia eteched for use as the bu	resulting in death) L	ast	d		162571			T FA	ILUR	4					
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ć	The law ste has page 2										10	Yas 2)	CNO	1 🗆 Yas		
	r VICAL TA yalclan: The I gractor, page fo Be Com	25. Was case referre	ed to medical							ca of Dea	th (Check only	one)				
	Physic of this of this of the sel direction of the	1 Yas 254				ER/Outpatle			4U N	lursing He	ome 5 Res			ecify)		
	ding P. Affer funer funer	1 Natural	5 Panding invastigation		ot tnjury oth, Dey Year)	28b. Tima o Injury	м	28c. tnjur Wor	yat k? Yas 2[1No	28d. Describe	now injury	occurred			
	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To the Funeurs after this certificate has been signed by the attending picompletaly filled in by the funeral director, page 2 should be deteched for use as a Medical Certification: To Be Completed by Physician/Mec	2 Accident 3 Suicida 4 Homloida	6 Could not be datarmined	28a. Place	a of Injury - At he ing, atc. (Specif		reet, fector				28f. Location City or To	(Street and wn, Stata)	Number or F	Rural Route	a Number,	
	To the Hospital or At within 24 hours after of to the Funeral Direct completally filled in by Medical Certifi	(Check only	Certifying Pi	hysician: To the	a best of my kno	wledge, deet	h occurred	at tha tir	ne, data a	nd place,	and dua to the	causa(s) e	and mennar a	is stated.	ause(s)	
	the Property of the Property o	one) 29b. Signeture and t		and mar	nnar stated.				e number				signed (Mor			
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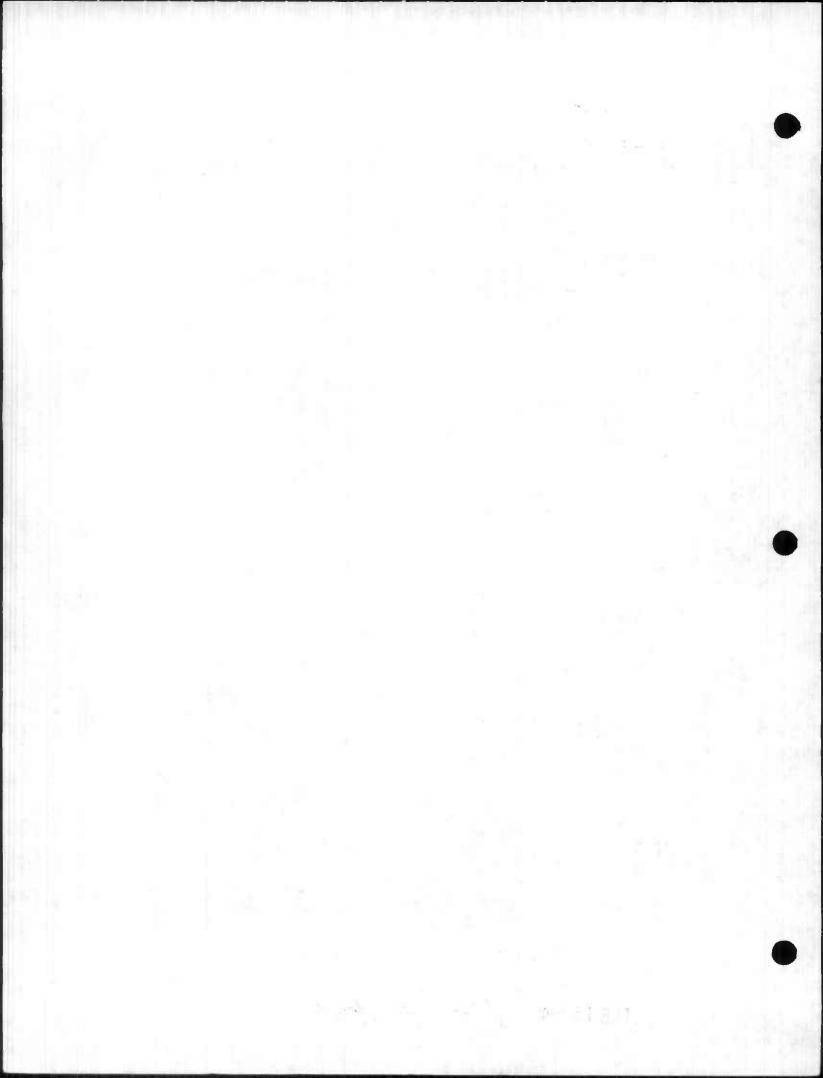


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** SOMIN FEBRUARY 11, 2000 4:08 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner SINAI HOSPITAL BALTIMORE If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Deys Hours Min 12M 20 F 093-60-3721 Yrs. 83 Director RUSSIA Usual Residence of Decedent 10a Stete 10b. Count 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Maryla 1 Yes 2 □ No MD N/A Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or the Medical Examiner must be 3615 FORDS LANE #618 21215 U.S.A. Funeral flied within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry E S Elementary/Secondery (0-12) College (1-4or 5+) 12 CONTRACTOR **APPLIANCES** ¥ 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill mant of Health and Mental H lant. If them 27 is marked off (UNKNOWN) (UNKNOWN) 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) SARA SOMIN / WIFE 3615 FORDS LANE #618 - BALTIMORE, MD 21215 Baltimore, 20b. Ptace of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State important if the any injury or oth anse 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removei from State HAR SINAI CEMETERY 2/13/00 OWINGS MILLS, MD 4 ☐ Donation , 5 ☐ Other (Specify) 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 her the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, heart failure. List only one cause on each line. Approximete Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical mediate cardiac anest **Examiner** Due to (or as e consequence of): Physician/Medical Examiner MOXIA The law requires that the death certificate be assecuted attending physician and for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events (or as a consequence of) Box 68760, Movo Calmia that initieted events resulting in deeth) Last Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by 1 Yes 2 No 3 Probably 4 Unknown milloma Division of Vitai Records. þ 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed has 2 0 No 1 Yes 2 No 1 Yes certificata or Attending Physician: 89 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 2Q €R/Outpatient 3□ DOA nours after death, neral Director: After this filled in by the funeral dir After this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending Investigation Matural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) w 025039 00 30. Name and address of person w/o completed cause of death (Item 23a) (Type, Print) with Ave. JAVGOBOVIFE 2838 MO 32. Registrer's Signature 31. Date filed (Month State Registrar

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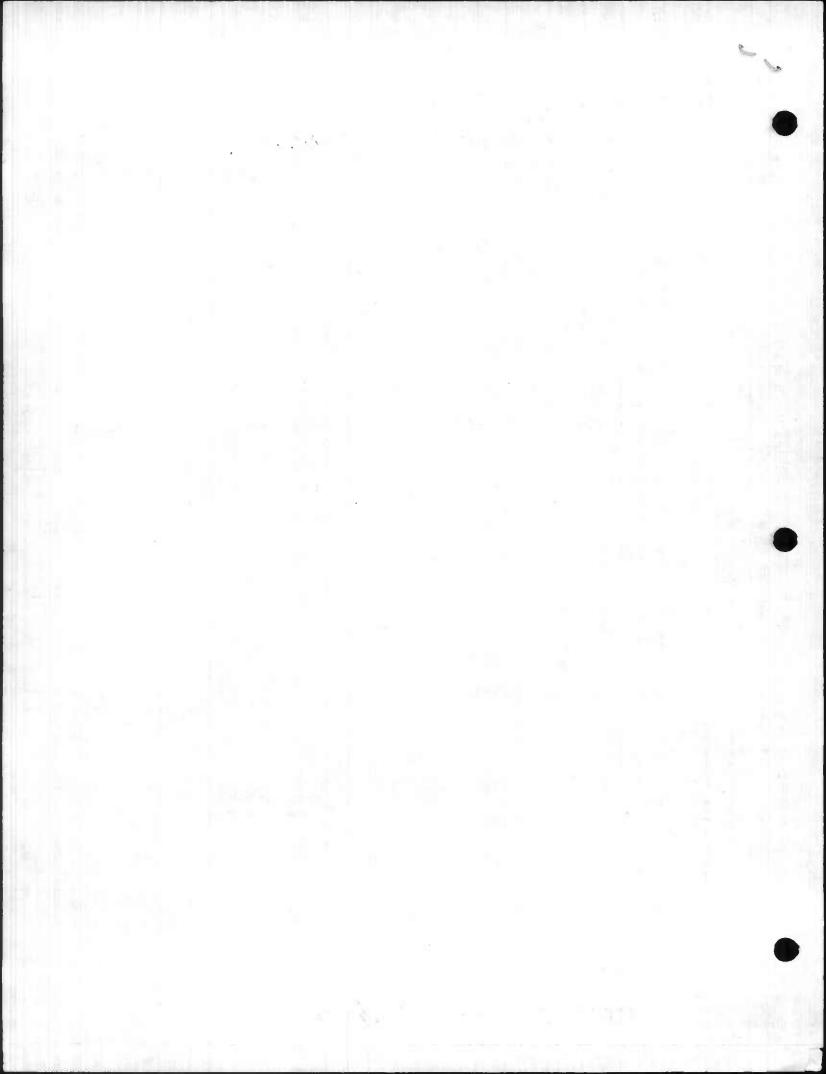
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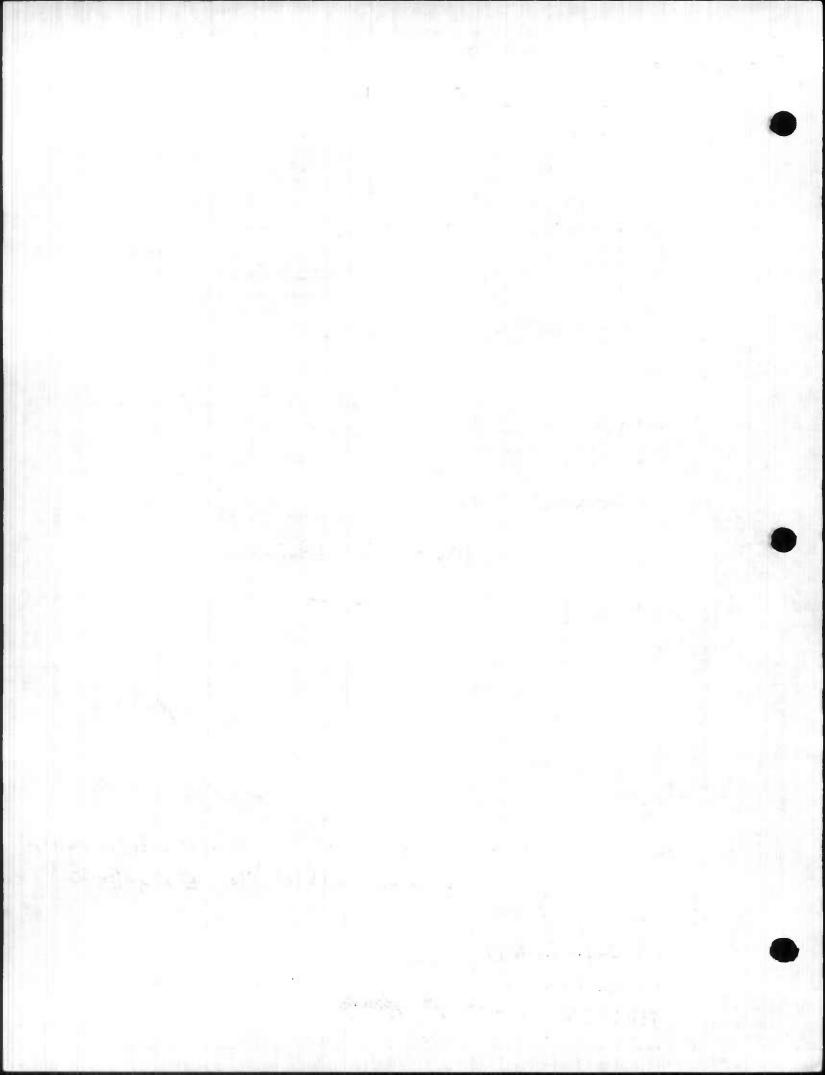


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND#23BbPER MD. G280 2-18-2000 J.A. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #26 PER MD #8 PER FH G780 2/15/2000 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** RUFUS TYREE THOMAS Feb 2000 5:25am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HAVRE DE GRACE HARFORD CO 2111 WILLIAMS DRIVE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1₩ 2□ F -7980yrs Director 214-16-9618 NOV. 28 1919 MARYLAND Usual Residence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow d other than "natural", or items 23a or 28a-f ahor evant, the Medical Examiner must be notified at Director 1 Yas 20(No MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2111 WILLIAMS DRIVE 21078 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 X Xas 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 ₹ Specify: Specify: P 3 Widowed 4 □ Divorced BLACK Year or Dates: 41/45 Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FOOD 12th grade COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental le marked FRANCES G. THOMAS 0 REV. HENRY THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of the Department. If them 27 is Important. or other fry 128 Montague Lane, Elton, Maryland 21921 Oran Thomas/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cematery, crematory or other place) 1XX Burial 2 Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) HAVRE DE GRACE, MARYLAND JAMES A.ME. CHURCH 2/15 21 Signature of Europeal Service License 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 321 S. PHILADELPHIA BLVD, ABERDEEN MD. 21001 Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final diseasa or condition resulting in death) Examiner Examiner ta w The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? TO 100 2 No 3 Probably 4 Unknown Records, à 5 8 Mulliker 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes page 2 1 Yes 2 ING 1 Yes 2 No certificate Division of Vital Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Mesidence 6 Other (Specify) Certification: To 1 Tyes 2 TO No 1 Inpatient 25 EN/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 5 Pending Investigation or Attending 1 Natural 1 Yes 2 No death. 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled In 24 hours a Hospital edical 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. teh (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. within 2 To the \$ 29b. Signature and title of our file 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Leticia S. Galvez, M.D., 625 S. Union Avenue, Havre de Grace, MD 31. Date filed (Month, Day, Year) FEB 15 32. Registrar's Signature State 2000 Registrar

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AS ED		R ME G780 2/29/2000 AH	State of Maryland / Dep Ce	ertificate of L		Hygiene Reg. No.	04756		
8	Physician /Medical	1. Decedent's Name (First, Middle, Last)	JOSE ALBERTO VASQUEZ	Mont	2. Date of Death Month Pay 12 2000 4:33 A				
	Examiner	4a Facility Name (If not institution, give str		4	b. City, Town, or Location of BALTIMORE	Death 4c. County of I			
	Funeral Director	OHIGHOWIN	7. Age (In yrs. last birthday 2 F 28 Yrs.	Months Days	Hours Min. 8. Date (Mont	of Birth th, Day, Year) 9.	Birthplace (State or Foreign Country) EL SALVADOR		
	deeth with the Meryland ms 23s or 23s-4 show Limset be notified at neral Director	Usual Residence of Decedent 10a. State 10b. County MD . N/A	10c. City, Town or L BALTIMO	RE			10d. Inside City Limits 1 ☒ Yes 2 ☐ No		
	burs effer deeth with the Merylen set, or Neme 23s or 28s-f show that is notified at 1 by Funeral Director	10e. Street and Number 116 N. EAST AVENUE 11. Marital Status 12	. Was Decedent Ever in U,S. 13.	10f. Zip Code 2122	4 spanic Origin? (Specify Yes n, Mexican, Puerto Rican, etc	EL SALVAD	OR American Indian,		
0020			1 Yes 2 No If Yes, Give Year or Dates:	1 X Yes 2 □ No	Specify: SALVADOR	AN Specify:	White, etc.		
ylan ylan	led within 72 ho lyglene. Wer then "neturn it, the Wedgell Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) (Giv life.	edent's Usual Occupe e kind of work done o DO NOT use retired INE OPERA	turing most of working)	SOIL SAF			
	should be filed nd Mentei Hygi merked other imetic event, I	17. Father's Name (First, Middle, Last) UNKNOWN 19a. Informant's Name/Relationship (Type	Philad	in Address (Street	18. Mother's Name (First, M THERESA R) and Number or Rural Route N	AMIREZ	to Zin Codal		
	of Heelth of Nem 27 le	MARIA RAMIREZ/ SIST 20a. Method of Disposition 1 Burial 2 Ø Cremation 3 Ren	ER 116	N. EAST A	VENUE, BALTIMOI		21224		
Baltimore,	pemit. Pegee Department of I Important: If Ne eny Injury or of phose.	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	GREENMOU	NT CEMETER 12. Name and Addres ILLY & ZEI			,MARYLAND		
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	titions that caused the death. Do not er cause on each line. Due to (or as a conse	iter the mode of dying	RN AVENUE, BAL- g, such as cardiac or respiral	TIMORE, MARYL lory arrest,	AND 21231 Approximate Interval Between Onset and Death		
Box 68760,	certificate be executed nding physicien and use as the burle-transit and any and any and any any and any any and any any any and any	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
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Records,	The lew requires the pate has been signe, page 2 should be completed by				24a.	Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?		
	et te ped	25. Was case referred to medical examiner?		low	26. Place of Death (Check	yoves 2□ No only one)	Ves 2□ No		
Division of Vital	After this funeral	27. Manner of Death 1 Natural 5 Pending investigation	spital: 1 ☐ Inpatient 2 ☐ EF/Outpetie 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Place of Injury - At pome, farm, s building, etc. (Specify)	M 28c Injury treet, factory, office	es 2 No Self. Loca	Residence 6 Mother (pribe how injury occurred a Constitution (Street and Number of Town, State)	Specify) SCENE Lin Miller or Rural Floute Number. He ST		
	To the Hospital or Attend within 24 hours after deet To the Funeral Director: completely filled in by the Medical Certificat	(Check and 20 Medical Examiner	ian: To the best of my knowledge, dea r: On the basis of examination and/or in and manner stated.	th occurred at the tim nvestigation, in my op	ne, date and place, and due to pinion, death occurred at the	o the cause(s) and mannitime, date and place, and	d due to the cause(s)		
	To within com	20th. Signature and title of certifier Carbon Company	M	29c. License		29d. Date signed (A FEBRUARY			
	State	JUAPON LOCKE 31. Date filed (Month, Day, Year)	pleted cause of death (Item 23a) (Type		Street, Balt	timore, Mary	land 21201		
	Registrar	FEB 1 5 2000	property /	1					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 JOSEPH 00 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LYND HURST BALTIMORE If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 10M 20F Months Hours 216-24-3638 Usual Residence of Decedent 70 916-10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BAITIMORE 1 No Yea 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? NOHURST 2122 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL CUSTODIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SE Ph LilliAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Neme/Relationship (Type, Print) WhitE LYNDHURSTSt. BA1to, Md. 21229 AURELIA - SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 18 Burial 2 Cremation 3 Removal from State 2-17-00 CROWNSVIILE ANNE ARdUNEL md. 4 Donation 5 Other (Specify) VEI 21. Signeture of Funeral Service Licentification 22. Name and Address of Facility FUNERAL SERVICE-170, Mª Culloh ST. neu La Douglass an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Mellitue tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0020

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Examiner physician and the buriel-transit Be Completed by Physician/Medical edical Certification: To After To the Hospital or must within 24 hours after death.
To the Funeral Director: After must be fulled in by the fur

Division of Vital Records, P.O. Box 68760,

or Attending Physician: The law requires

Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part t.

1 Yes 2 No 3 Probably A Unknown

tection

24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 10 No 1 ☐ Yas 2 ☐ No

25. Wes case referred to medical examiner? 1 Yes 2 No

26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Yes 2 No

27. Manger of Death 1 Matural 5 Pending 2 ☐ Accident 3 Suicide

CHAN

4 Homicide

investigetion 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

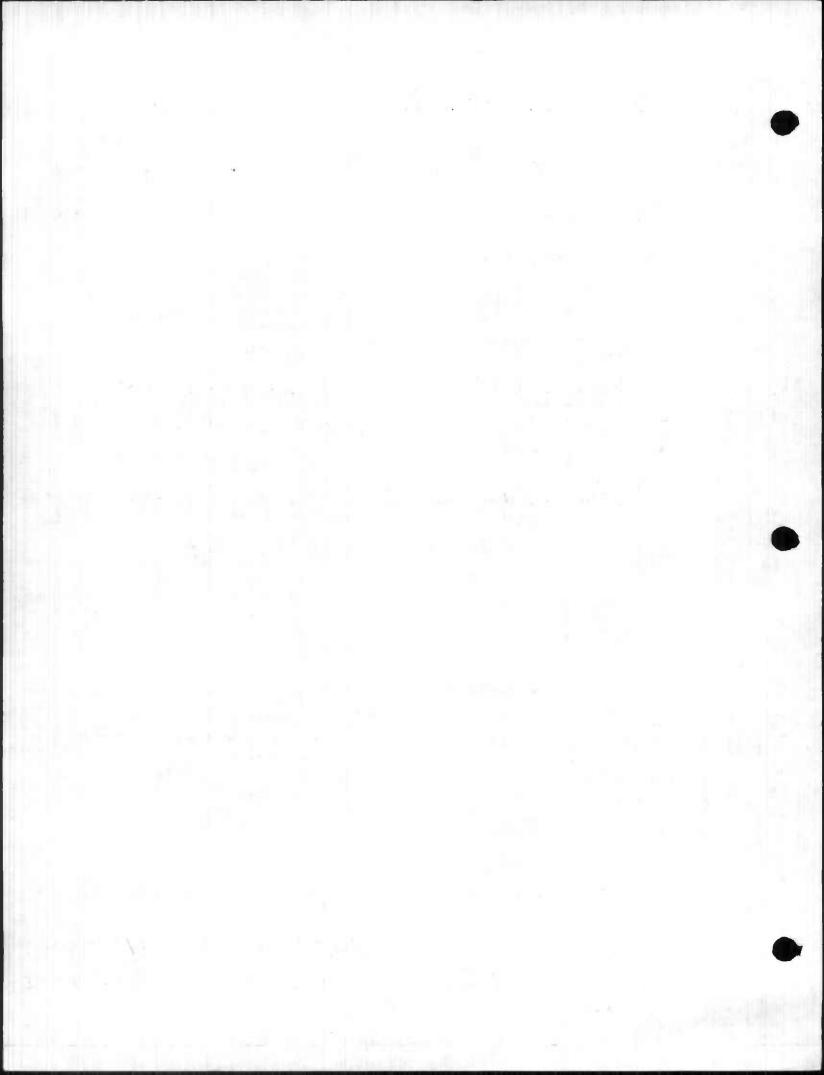
29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMORE

State Registrar 2000 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0135 HARLES ALEXANDER WILLIAMS JAN. ,2000 JR. 26 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HUnder 24 Hrs. 8. Date of Month HOSPITAL ECOURS 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 12M 2□ F Hours 218-44-7882 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No MARULAND 10g. Cifizen of What Country? 10e. Street and Number 10f. Zip Code 3 AVENUE MONDSON 21221 USA. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BALTO, CITY SCHOOLS TEACHER MASTERS DEGREE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARLES WILLIAMS SR. MAUDE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 08 BARBARA A. WILLIAMS (SISTER) FULTON AVE. WITA, BALTINGE, MO. 212/7 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) L⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 02-05-00 BALTIHORE 4 Donetion 5 DOther (Specify) ARBUTUS CEMETERY BROWN JR. FUNERAL HOME 22. Name and Address of Facility JOSE PH H 21. Signature of Funeral Service Licenses JOSEPH -2140 N. FULTON AVE. BALTIMORE, MD. 2.121 ulica 23a-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death . Metabolic acidosis consistent with chemical ingestion Immediate Causa (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 12 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No an 7,2000 Ingested chemica 15 2 Accident Unknown 3 Suicide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner physician and the burlei-transit The lew requires that the death certificets be asseuted Box 68760. Physician/Medical D.O. Records, þ Completed page 2 Division of Vital Attending Physician: Be Certification: To this After Funeral Director: After the further of the further

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permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental hygiens. Important: If frem 27 is marked other than "natural" any injury or other treumatic average.

25. Was case referred to medical examiner? 1 ✓ Yes 2 ☐ No 27. Manner of Death 1 Natural

281. Lodation (Street and Number or Rural Route Number, City or Igwn, State) 2531 Edmonton Ave Box Ho MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

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29c. License number

29d. Date signed (Month, Day, Year) 2,2000

30. Name and adde d cause of death (Item 23a) (Type, Print) ME

OC aron 31. Date filed (Moralf, Day, Year)

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32. Registrar's Signature

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Penn St. Balto MD 21201

State Registrar

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29a. Certifier (Check only one)

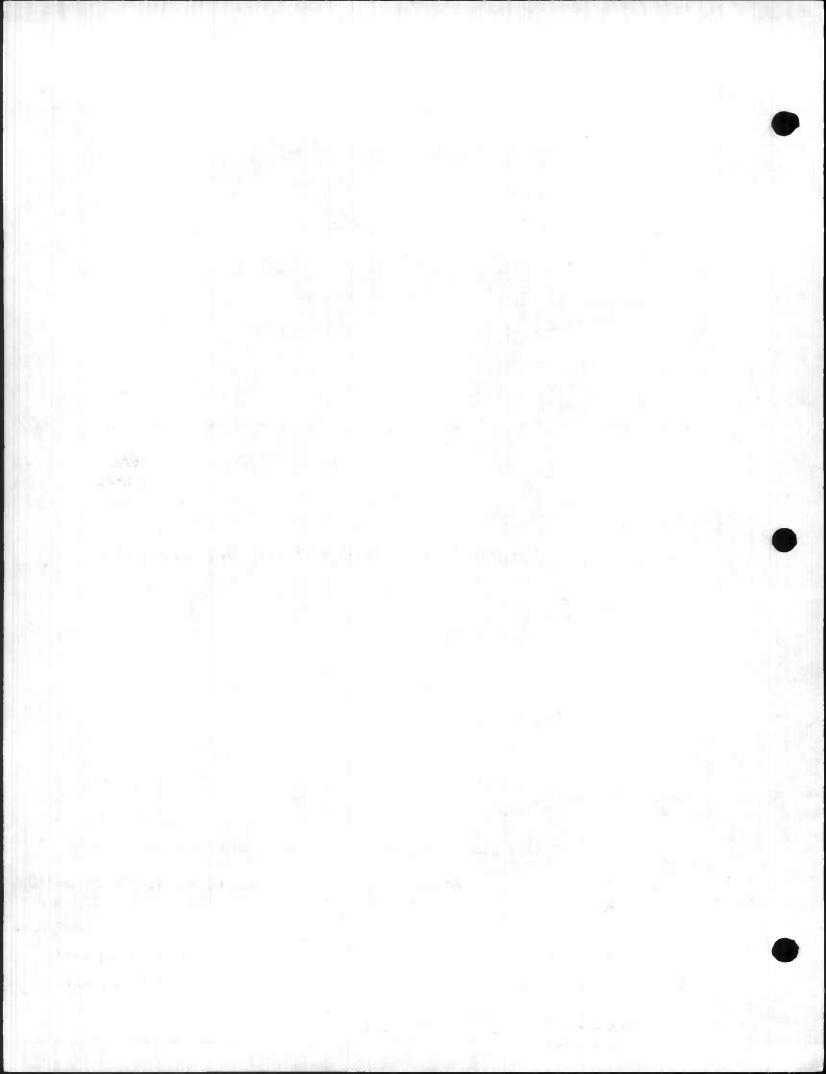
29b. Signature and title of profile

DHMH 16 Ray 6/95

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Hospital

To the P



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** FEBRUARY 2000 3:35 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Center Baltimore TOWSOR If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 10€M 2□F 219-14-Yrs. 219-14-1060 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified 1 Yes 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 21234 234 Funeral Was Decedent Ever in U,S. Armed Forces? 1 MYes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. 11. Marital Status hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 24 filed within Hygiera. Elementary/Secondary (0-12) College (1-4or 5+) COM unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 8 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # nomas ot of Health a ii if Item 27 is r or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 1 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2000 21. Signature of Edneral Service Licenses 22. Name and Address of Fecility Vaks Sed Md 21234 (23a. Parf). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CANCER OF THE LIVER 3 MONTHS disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) for use as signed by the at I be detached for P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 SUnknown 1 ☐ Yes 2 ☐ No Records, by Completed 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 S Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident e Hospital or Attend n 24 hours after death e Funeral Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and dua to the cause(s) and manner stated. within 2 To the 200

State Registrar

31. Date filed (Month, Day, Year) 5 2000

30. Name and address of person who completed cause of death (I)em 23a) (Type, Print)

29b. Signature and title of certified

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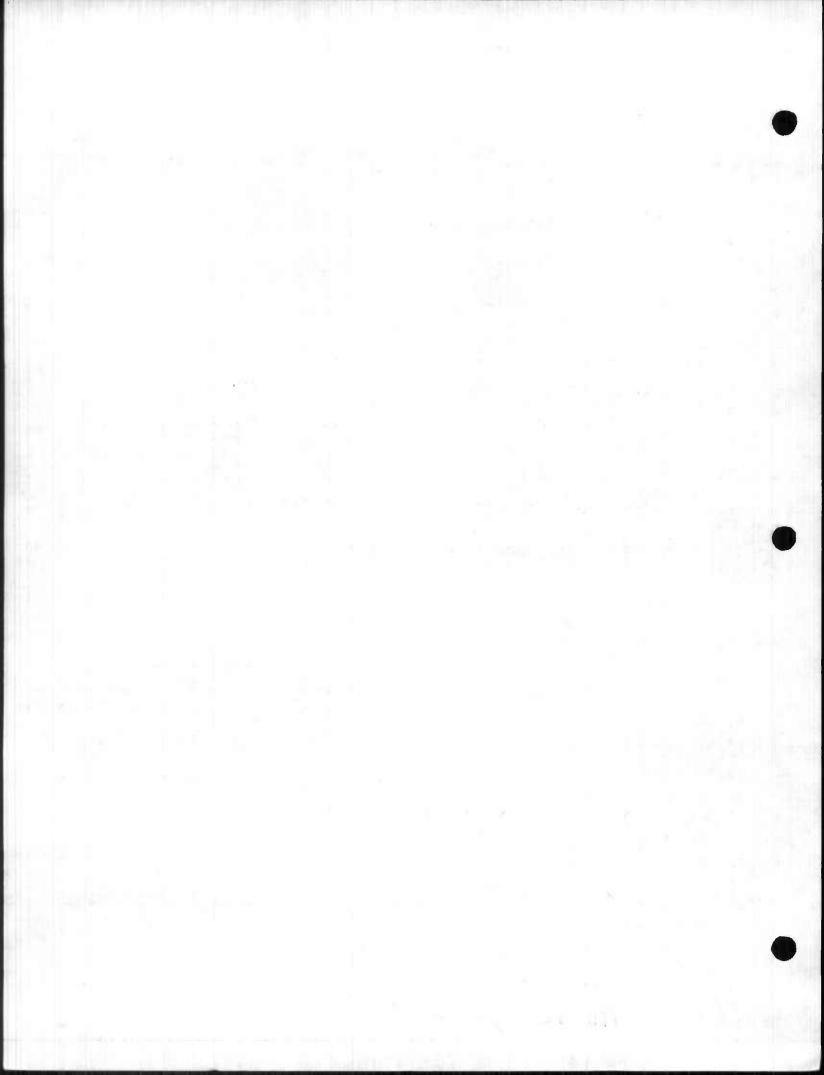


OSLER DRIVE, TOWSON, MARYLAND 21204

29c. License number

D25102

29d. Date signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene 00 04760

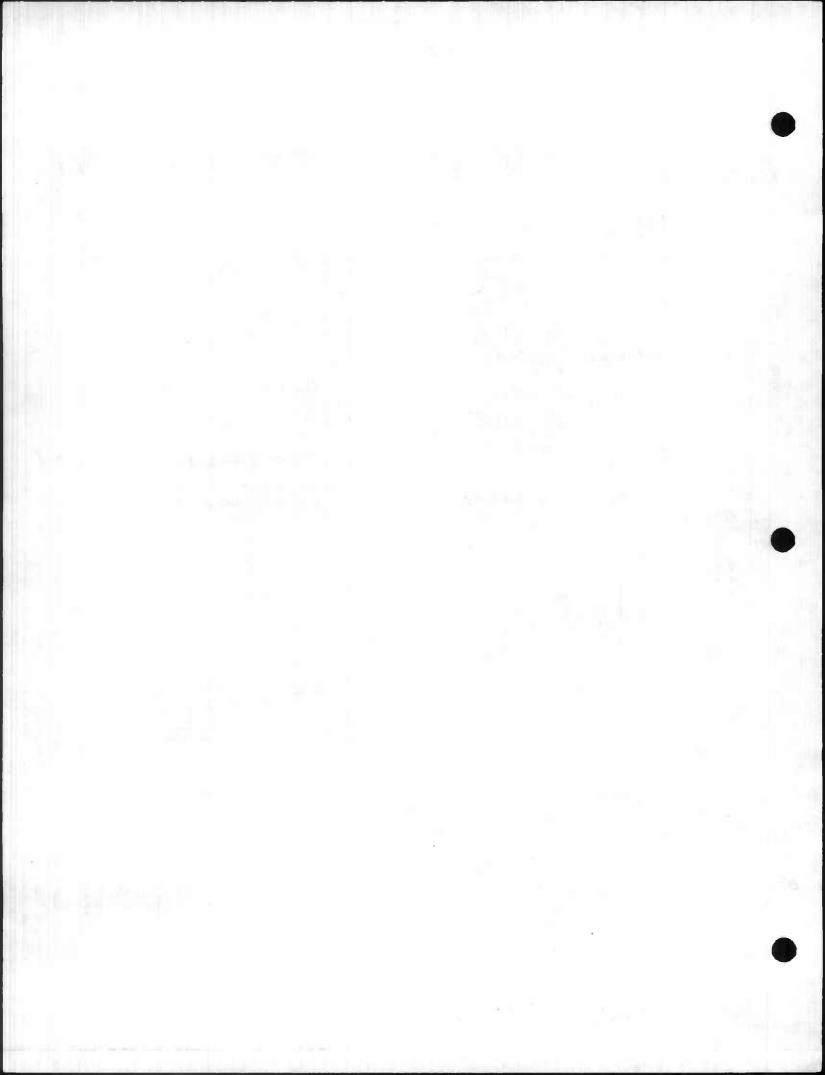
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State of Maryland / Department of Health and Mental Hygiene

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E	Pa Pa		4 Donation 5 Other (Specif		MISON F	-orest Vet	12-17-00	QWing	S M.	11/5,14
a	permit. Pag Department Important: I any Injury o		21. Signeture of Funeral Service Licer	1968		nd Address of Facility	,	7		
m	SOES		1	March	Marci	RF.H.W.	est of	B	0 11.	red ZIZIS
	_		23a. Part Enter the disease, or com	unlications that anyead the death. F	4300	0 Waloas	h Huer			Approximate
4			shock, or heart failure. List only	one cause on each line.	o not enter the mo	oo or cyrig, soon as can	unac or respiratory	arrost,		Interval Between Onset end Death
	Physician		Company of the Compan						1	Oriset end Death
	/Medical Examiner		Immediate Cause (Final disease or condition	. Seps	15				1	3 days
	CAMITICI	10	resulting in death)		a consequence of):	:			1	,
	D 5	De l								
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions,	b. Due to (or es	a consequence of):	:			<u> </u>	
ó	exe in ar rial-t	EX	if any, leading to immediate							
68760,	sicie 9 bu	edicai	cause. Entar Underlying Cause (Disease or injury that initiated events	C. Due to for se	a consequence of):					
28	ficat phy s th	8	resulting in death) Last	Due to (or as	a consequence or.					
×	ding ding	2		d						
Bo	death e atten	Physician								
o.	the de	VS	Part It. Other significant conditions of	ontributing to death but not resulting	g in the underlying o	cause given in Part I.	23b. Die	tobacco use co	ntribute to	the cause of death?
	that the	F.					10	Yes 2 No	3 Prob	ebly 4 Unknow
Ś	es that the death igned by the atte be detached for	by								
Hecord	- 07 TO	8						s an autopsy ormed?		re autopsy tindings alable prior to
S		Completed					_	Ormed?	con	npletion of cause seath?
e e	hes b	Ē								
=	E ag						1 🗆	Yes 2 No	1 🗆	Yes 2 No
VII a	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?				Death (Check only	one)		
5	Physic this c	2	1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient 2 ER/	Outpatient 3 D	OA Other: 4 Nursin	g Home 5 Res	idence 6 DOth	er (Specify	')
5	g P.		27. Menner of Death	28a. Dete of Injury (Month, Day Year) 28b	Time of Injury	28c. Injury at Work?	28d. Describe	how injury occur	red	
0	o ful	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		М	1 ☐ Yes 2 ☐ No				
2	Attending or deeth. ector: After by the fund	10	3 Suicide 6 Could not b	259. Place of injury - At nome,	tarm, street, fector	y, office	28f. Location	(Street and Numb	per or Rural	Route Number,
5	Dir.	Certification:	4 Homicide	building, etc. (Specify)			City or To	wn, State)		
	To the Hospital or Attanding I within 24 hours after deeth. To the Funeral Director: After completely filled in by the funer	2	29a. Certifier 17 Certifying Ph	ysician: To the best of my knowled	log death accurred	at the time date and of	ace and due to the	rausals) and ma	anner se et	atori
	Fun Fun yeek	edical		niner: On the besis of examination and manner stated.	and/or investigation	n, in my opinion, death o	ccurred et the time	, date and place,	and due to	the cause(s)
	thing a	Me		and manual stated.	100	c. License number		29d. Date signe	d /Manth I	Day Vand
	F 1 5 8	-	29b. Signature and title of certifier	1 -	29					
			Harra	hen MD	1 1	r 13404		Februa	M.	1,2000
			30. Name and address of person who	completed cause of death (Item 23r	a) (Type, Print)				11	
	0		Harold Pia	0.0		Freene.	St 200 +	Rallini	ore N	1,2000 1D 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature			01110.	Sections	1	
	Registr	-	FFR 1 5 2000	Denerger B.	Spark	1				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23aptI&II PERPHYG781 3/18/2000 EW Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Wilson helma February 2000 6 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death City, 10min, S.

Caltymore

It Under 24 Hrs.
Hours Min.

B. Date of Birth
(Month, Day, Year)

-21-1943 sinai Hospita If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Months Days 219-70-7425 Yrs Ma Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Md NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road U.S.A 4005 wood 21215 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 N.No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: Black 3 N Widowed 4 □ Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry UNK Elementery/Secondary (0-12) College (1-4or 5+) 12th grade NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mabel Masin Bernard romwel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Michele Daughter Edgewood Balto, Ad 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 12-15-00 4 □ Donation 5 □ Other (Specify) torast Vet 22. Name and Address of Facility Harch F. H. Wast 4300 Walkash f 21. Signature of Funeral Service Licensee Will Walsash Avenue Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month Due to (or as month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 ☐ Yes 1 □Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: 1 Inpatient examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manger of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

10

Funeral

Director

77 is marked other than "natural", or flams 23s or 28s-f show traumsitic event, the Medical Examiner must be neutred at

permit. Peges 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: if item 27 is marked other than fast any Injury or other traumatic event, the Medica once.

with the Maryland

72 hours after death

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ

signed by the attending physician and d be detached for use as the burial-transit

P.O. Box 68760 Division of Vital Records. of effector: After 1 To the Hospital o within 24 hours of To the Funeral D

Be 2 Certification: Medical

Registrar

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shynola

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending Investigation

6 Could not be determined

31. Date tiled (Month, Day, Year) FEB 1 5 2000

29b. Signature and title of certifier

Sinai 32. Registrar's Signature

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Injury

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

6,2000

ORIGINAL

113 233 James of Jacker

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month 830 pm **Physician** 2000 ngaRd 13 rebruary /Medical 4a Facility Nama (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles 505 tRoutus Lane Marden Choice Altimore If Under 24 Hrs. If Under 1 Yes 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birtholaca (Stata or Foraign 6. Sex Funeral 10 M 20 F Months Days Hours 23-10-0511 December 24 1915 New Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits 1 Yas 2□No Director ARbutus 289-1 MARY kind 12 JAHIMORE 10f. Zip Code 10g, Citizen of What Country? ò Maiden 21228 USA Lane Ap C items 23a st Charles noice Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 12 Yes 2 No 17 Yes, Giva 19 Afric Year or Datas. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · Amarican Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mentei Hygiene. Interpretant: if Item 27 is marked other than "natural", or tentions any injury or other traumatic event, the Menter Black, Whita, etc. 1 Never Married 2 Married 1 Yas 2 No Specify Specify: à 3 Widowed 4 Divorced 1943 AUCASIAN Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Nama (First Middle Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 8 Tlice LOOMAS 19a. Informant's Name/Ralationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Villiam Win gard SL. AA. St. Chanks raider Choice LANE Anburks md. 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Data 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stata /2000 4 Donation 5 Other (Specify) MARYhad athedra OAHMORE. FUNERAL SURVICE 21. Signature of Funeral Sarvice Licenses 22. Nama and Address of Facility Leleas M. WHOLACE 3405 W. FRANKlin BAltimore 54 celesses ceau m. 1229 23a. Part. Enlar to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** Several Alzheimer /Medical Immediata Causa (Final 'S disease or condition resulting in death) years Examiner Due to (or as a consequence of) Examiner physician and the burlei-transit The lew requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown à 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 🗆 Yas 2 TAN 1 ☐ Yas 2 ☐ No Attending Physician: 25. Was case refarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 Yas 2 HN6 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 Tyes 2 No invastigation hours efter deeth. 2 Accident Director: To the Hospital or Atterwithin 24 hours efter ded To the Funeral Director completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicide

State Registrar

edical

29a. Certifier

(Check only onel

Baltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

31. Data filed (Month, Day, Year) 5 2000 FEB

29b. Signature and tale of certifie

Maiden Stone 32. Registrar's Signatura

Choice Lane, Baltimore, MD 21228

29d. Dale signed (Month, Day, Year)

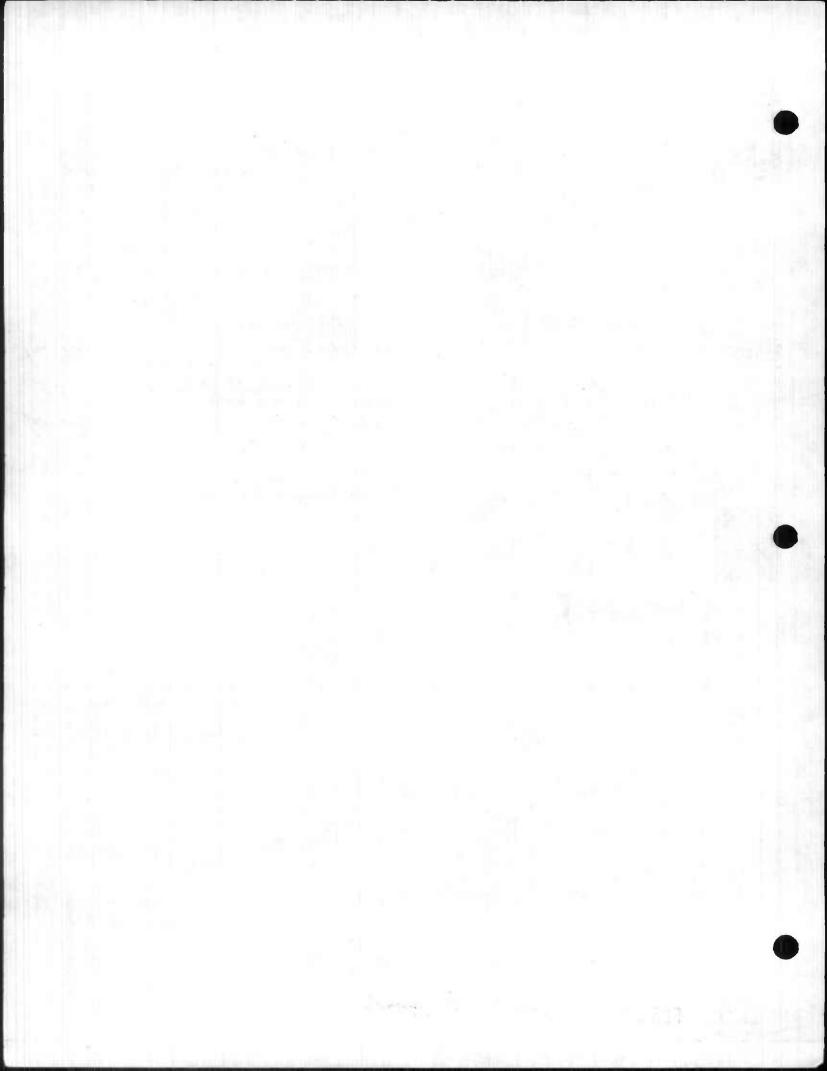
DHMH 16 Rev 6/95

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) 04764 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Mildred Ada Whiteman February 13 2000 1545 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 M 253/F 209-07-1205 Yrs. 86 May 15, 1913 Pennsylvania Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County XXYas 2 No Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Bestgate Road 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, 11 Marital Status Black White etc. ☐ Yes 2000No 1 Never Merried 2 Married 1 ☐ Yes 20 No Specify: White Specify XXWidowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Telephone Company Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Morris Sparr Sarah Wasserman 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Lawrence R. Vinson (Nephew) 309 Halsey Road, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 02/15/ 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 2000 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that card ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Approximete Interval Between Onset and Death Immediate Cause (Final Corolio ses maloy disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to do ada Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy tindings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 No 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending 1 Yea 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records,

Examiner the burial-tran and physician Physician/Medical signed by the attending to be detached for use by Completed this certificate or Attending Physician: Be Certification: To funeral Affer death. the within 24 hours after deat To the Funeral Director: filled in by Hospital

Physician

/Medical

Examiner

Funeral

Director

show

must be notified at

Hems

8

"naturel",

i Hygiene.

. Pages 1 and 2 should be fill iment of Health and Mental Heart: If item 27 is marked oth lury or other trsumatic even

Department or Important: If eny injury or once.

Physician /Medical

Examiner

Funeral Director

Completed by

death with the Manyland

filed within 72 hours after

Baltimore, Maryland 21215-0020

completely

a de

0

State Registrar

Medical

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

29c. License number 00051437

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

ANNADOLIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

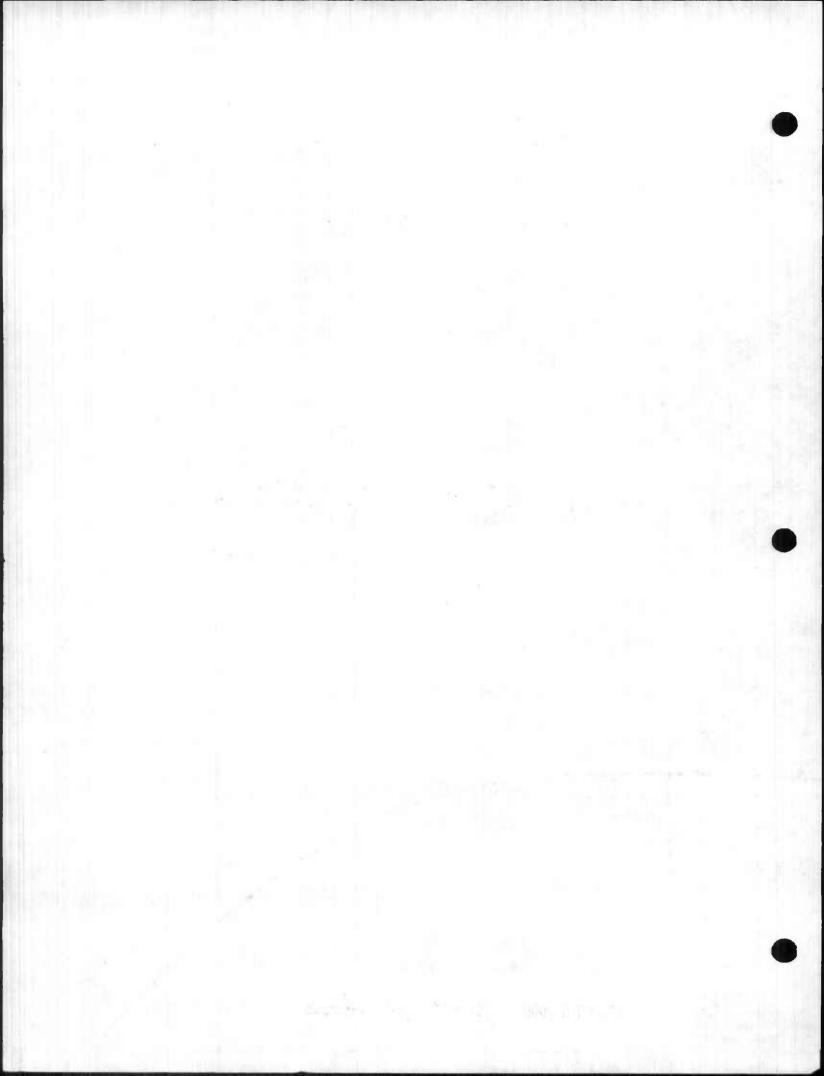
181TOYE DTC & DWO DARCY

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

FRANKLIN ST

1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

32. Register's Signature 31. Dete filed (Month, Day, Year) FEB 15 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene G780 2-22-2000 Certificate of Death AMEND ITEM: #8 PER F.H. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day 9, 2000 February Physician With, Jr. 10:15PM Joseph /Medical 4d County of Death 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rehabilitation and Extended Care Baltimore if Under 24 Hrs. 8. Date of Birth 9-20
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) if Under 1 Year 5. Sociei Security Number Birthplaca (State or Foreign Country) 6. Sex **Funeral** 12 M 2 F Months Days 218-26-6764 69 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or frams 23a or 28a-f ahow traumatic event, the Modical Examiner must be notified at 1 Yes 2 □ No Director MD Baltimore City N/A 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 1408 Anglesea St. 21224 Apt. 1D U.S.A. Funerai Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Sfetus Bleck, White, etc. 1 Z Yes 2 No If Yes, Give Year or Dates: WW 1 ☑ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. by 3 Widowed 4 Divorced II White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier Postal 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Joseph F. Witt Josephine Zablewski 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) mit. Pages 1 and 2 partment of Health a portant: If item 27 is y injury or other trains Anne Susie / Aunt 6920 Donachie Rd. Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from Stete permit. Page Department Important: If any injury or Laurel, MD 4 ☐ Donation. 5 ☐ Other (Specify) Baltimore-Washington 2-15 22. Name and Address of Facility 21. Signature of Funeral Servica Licenses Moran-Ashton-Dabrowski Funeral Home, Inc 23a. Part1. Enter the disease, shock, or heart failure. Unread the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Unread the cause on each line. Baltimore ST. Baltimore, MD21224 Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Hepatic metastasis 3 months disease or condition resulting in deeth) Examiner of unknown origin Examiner Haenocarcinoma physicien and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Ves 2 No Division of Vital I 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending Investigation 1 Natural deeth. 1 Yes 2 No 2 Accident e Hospital or Attendi n 24 hours after deeth e Funeral Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 [Iv Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated. 29a. Certifier edical 2 Madical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the Vithin 2 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signetura and title of certifier D0032548 February 10,2000

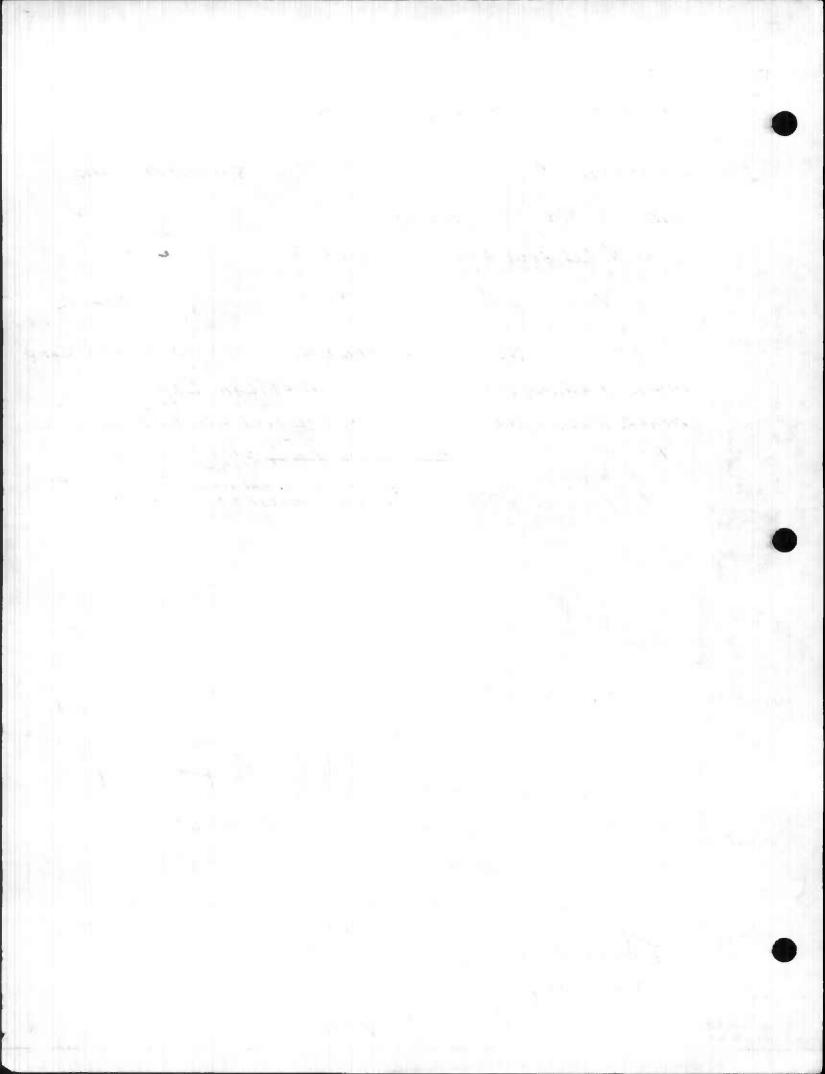
State Registrar

FEB 15 2000

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 10 North Greene Street Refly L. COLVIN Baltimore, Mary 1944 32. Registrats Signature

P²²(15) a) The last section of 17. of the control of the same is not a state from the OPEN CAMPAGE THE STATE OF

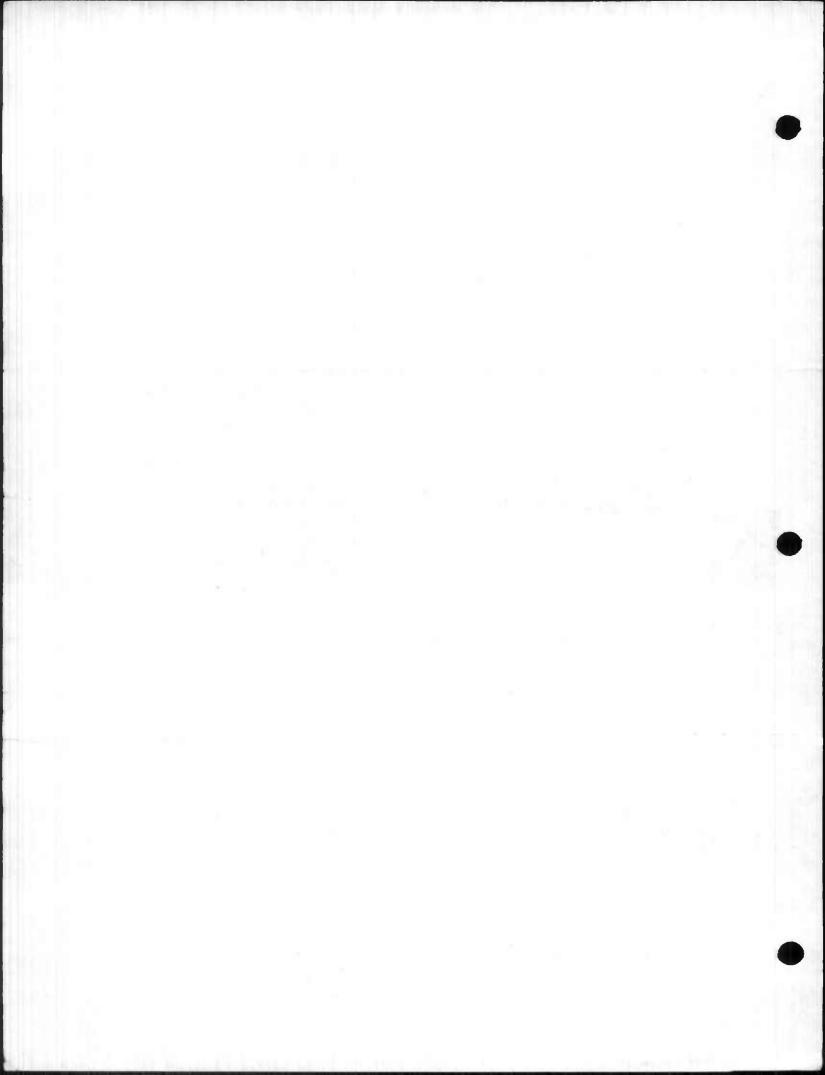
hysician	1. Decedan		/2000 A			Certificate	0. 000		2. Date of D			3. Time of Death
/Medical	11/1/	VdE	R	WAS	SHING	TON, 3	SR		Februa:	ry 08	2000 O	5:53 P.M
xaminer	de Facility			ive street and number	er)		4b. City		ocation of Dear	th 4c. County	of Deeth	
	5. Social Se			Hopkins H		irthday) If Under 1		Baltim Ider 24 Hrs.			1/A	(0)
	216-	50-39	143	Sex 100 M 2□ F	Age (In yrs. last t		lays Hou		(Month, D	ey, Year) -1949		e (Stete or Foreign
	10a. State	100	b. County	/.	10c. City, To	wn or Location					10d.	Inside City Limits
Director	MO		N/	A	BAG	-To.						1 PYes 2 □ No
		and Number	,	. / .		10f. Zip Co	de 2/3	2		10g. Citizen of		7
	11. Merital :	8 N.	ELL	12. Wes Decede		13. Wes Deceden			ecify Yes or N		ce - American	Indian,
			2 Merried				/		Rican, etc.)		ck, White, etc.	
		owed 4 🛭	Divorced	If Yes, Give Year or Date:	s:	1 ☐ Yes 2 ☐	Mo Spe	cny:		Specif	BLA	CK
		(Specify o	Decedent's lonly highest g	Education rade completed)	16	a. Decedent's Usual C (Give kind of work of life. DO NOT use i	lone during I	most of work	ing	16b. Kind of B	usiness/Indus	try
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	Examir Funerai	ner	7618 Donny Terrac 5. Social Security Number 6. Sex	7. Aga (In	yrs. last birthday)		Kingsvi	11e 8. Date of Bi	Balt:	LMOTE 9. Birthplace (State or Foreign
7	Director Puel		214-10-5561	84	Yrs.	ation		April	10,1915	Cumberland, Maryla 10d. Inside City Limits
	n the Many r 28a-f sh r roti ed	Director	Maryland Baltimore 10e. Street and Number	Ki	ingsville	10f. Zip Coda			10g. Citizan of V	1 ☐ Yes 2 ☒ No What Country?
21215-0020	be filed within 72 hours efter death with the Maryland Ital Hygiene. od other than "natural", or items 23a or 28a-f show event, its Medical Examinar rival be notified at	by Funeral	1 Navar Married 2 Married 1 If 3 Widowed 4 Divorced Ye	es Decedent Evar med Forcas? Yas 2 DNo Yes, Giva ser or Datas:	1	□Yas 2XNo		pecify Yes or N o Rican, atc.)	Specify	White
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Maryland	should be find Mental H marked ott	To Be	17. Fether's Name (First, Middle, Last) William A. Withers 19a. Informant's Name/Relationship (Type, Pr	int)	19b Mailing	Address (Street	Martha E	lizabet		.у
Baltimore, Mai	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic once.		Mrs.Ruth L. Withers 20a. Mathod of Disposition 1 M Buriai 2 Cramation 3 Ramov 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	(Wife)	7618 Db. Place of Dispose cemetary, cremical Me Sunset Me 22. E	Donny Te ition (Nama of atory or other ple morial F Nama and Addre .F. Lassa	errace 	Kingsvi Data 2/12/2000 al Home	lle,MD.2	1087 City or Town, State and, MD.
	Physician /Medical Examiner	er	23e. Pert1. Entar tha disease, or complication shock, or heart failure. List only one caulimmediate Ceuse (Finel disease or condition resulting in death)	sa on aach lina.	death. Do not enter	r the mode of dyl		or respiratory	errast,	Approximata Interval Batween Onsat and Death
x 68760,	certificate be executed ding physician end se es the buriel-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated avants resulting in deeth) Lest		to (or es e consequ to (or as e consequ					
s, P.O. Box	law requires that the death certifies been signed by the attending as been signed by the attending by 2 should be detached for use e	by Physician/M	Part II. Other significant conditions contributi	ng to deeth but not	resulting in the und	dariying causa gi	van in Part I.	l tobacco use co] Yes 2⊠ No	obacco use contribute to the cause of death	
Records	aw requires to been so 2 should	Completed b							s an autopsy formed?	24b. Ware autopsy findings available prior to complation of ceuse of death?
Vital	T age	Be	25. Was casa referred to medical axaminar?	ıl·		Ott	26. Piece of Dee	oth (Check only		1 Yes 2 No
Division of	ttending Physical death.	ertification: To	27. Mannar of Death 1 Neturei 5 Panding 2 Accident investigation 3 Suicide 6 Could not be	Data of Injury (Month, Day Yas Placa of Injury -	At homa, farm, stra	28c. Inju Wo M 1	4 ⊔ Nursing H	28d. Dascribe		
Ö	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical Cert	29a. Certifiar (Check only 2 Medical Examiner: O	n the basis of axer	knowledga, daath	occurred at the ti	ma, data and placa opinion, daath occu	, and due to the	own, State) a causa(s) and me , date end place,	ennar as steted. end due to the ceusa(s)
	To the within: To the comple	Med	29b. Standard interpretation	allen	M.O.	29c. Lican:		>		d (Month, Day, Year)
	1241	te	30. Nama and address of person who complet Phyllis K, PullenMD 31. Data filed (Month, Day, Year)	ed cause of deeth	(Item 23e) (Type, P rusalen	rint) RQ	09620 Kingsu	ille, y	nd, 2	1087

State Registrar 31. Data filed (Month, Day, Year) FEB 1 4 2000 32. Ragistal's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 00 200 /Medical 4a Facility Name (If not institution, give street and pu 4b. City, Town, or Location of Death 4c. County of Death Examiner of 5. Social Security Number 8. Date of Birth (Month, Day, 6 Sax 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** -4846 10 M 20 F Months Days Min Yrs. Director idence of Decedent the Manyland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Maryles mant of Heelih end Mental Hyglane. Int: If Heen 27 is marked other than "natural", or frame 23a or 28e4 show many or other traumatte event, the states I Empires man to enother any or other traumatte event, the states I Empires. 1 Yes 2 No Director 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 OK Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whita, etc. 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1⊠Never Married 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify: Specify: KOPDAN Ś 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) // 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sugname) 19a, Informant's Nema Relationship (Type, Print) 19b. Mailing Address (Street and Number on Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Neme of cemetery, cremetory or other p Feb 14 20a. Method of Disposition 20c. Location - City or Town, State Department of important: If It eny injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Valley 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility vans Chape) 23a Port1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finei disease or condition resulting in death) /Medical **Examiner** Due to (or es a consequence of) Physician/Medical Examiner physicien end the burial-transit The lew requires that the deeth certificate be assected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of): ettending p Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 | Yes 2 | No 3 Probably 4 Unknown ate has been signed page 2 should be de þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed certificate has 1 XYes 2 No 1 Yas 2□ No or Attending Physician: funaral director, 25. Was case referred to medicel axaminer? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Aftar 1 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of cedifier

Registrar

State

NOO

Signature

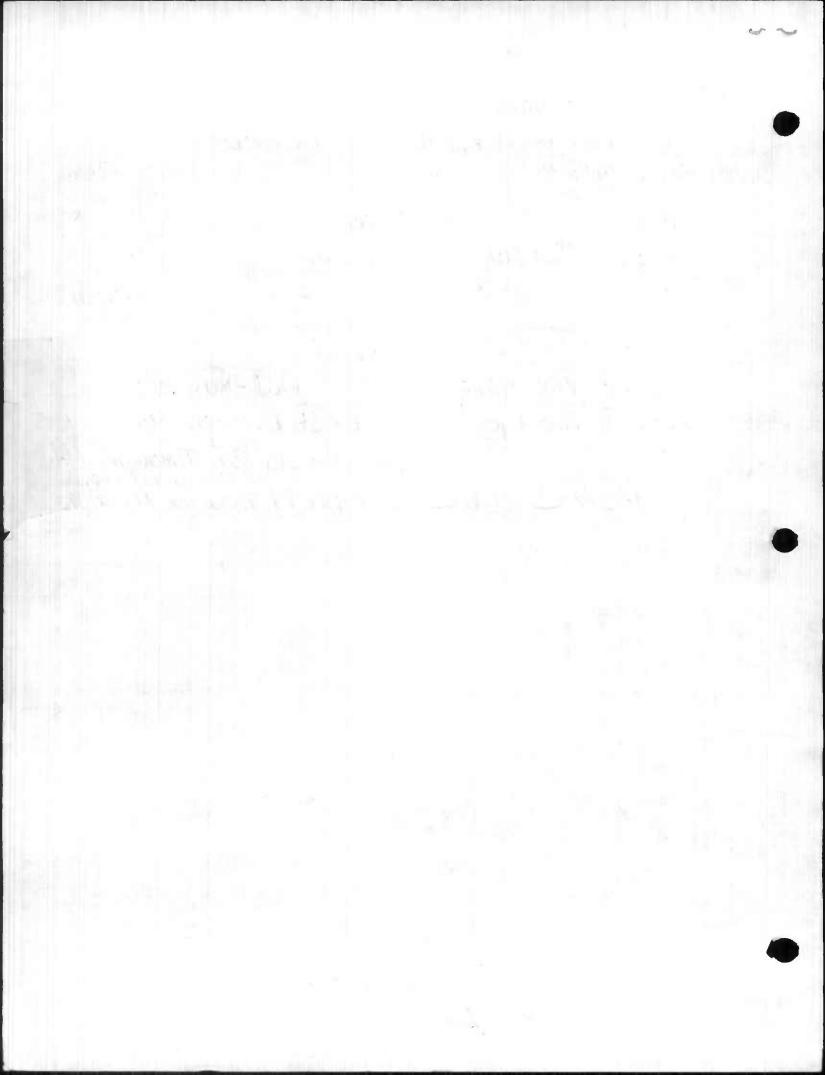
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar

31. Date filed (Month, Day, Year)

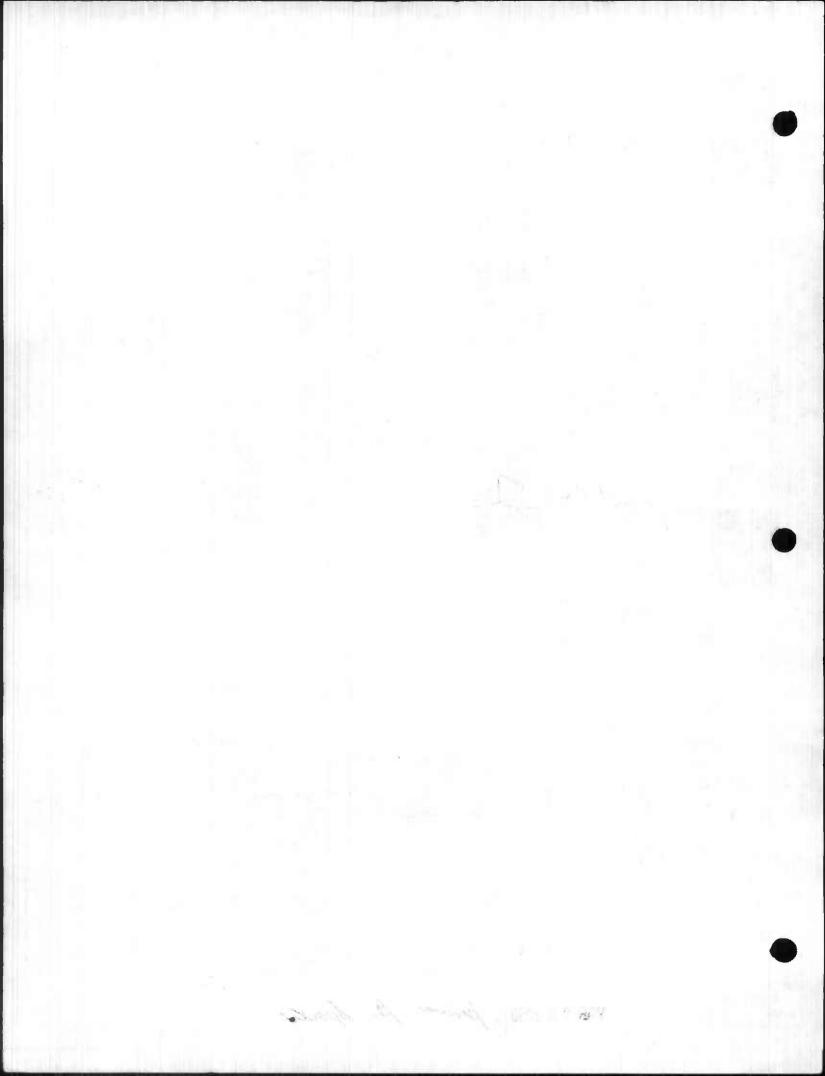
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Replacemen Certificate of Death Reg. No. I. Decedent'a Nema (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month **Physician** 30 2000 12:10 p.m. Venancio Parial Abelende Jan /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Naval Medical Center Bethesda Montgomery 8. Date of Birth (Month, Day, Year) May 2, 19 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours Yrs 586-60-6931 72 Director 1927 Philippines Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits mast be notified at 1 Yes 2 No Director Maryland Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rema 23a 12140 Dunleigh Court 20754 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 (2) Yes 2 | No II Hes, Give Year or Dates: 146-1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter d Department of Health and Mental hygiene. Important: If item 27 is marked other than "naturel", or item any injury or other treumatic event, the Medical Esperiment page. 1 Never Merried 2 Married Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Filipino by '46-'66 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Protective Services Dept. of Defense 8 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Felix Parial Ramona Abelende 19e. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Marie Abelende /Wife 12140 Dunleigh Court, Dunkirk, Maryland 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Feb Clinton, Maryland Resurrection Cemetery 3,2000 22. Name and Address of Facility 21. Signature of Funeret Service Licensee Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd. Owings, MD 20736 in 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, ock, or heart feilure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** . Wealt al Immediate Cause (Final disease or condition resulting in death) CARDIOMYOPATHY Examiner Due to (or as a consequence of): Examiner that the death certificate be executed physicien end s the burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) 8 P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknown signed t Records, þ The lew requires 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy performed? Completed page 2 a 1 Yes 2 No 1 ☐ Yes 2 No of Vital 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 70 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Division Hospital or Attending 1 Naturat
2 Accident 1 Yes 2 No deeth. Director: d in by the 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide aftar 24 hours of Funeral D letaly filled is TX Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

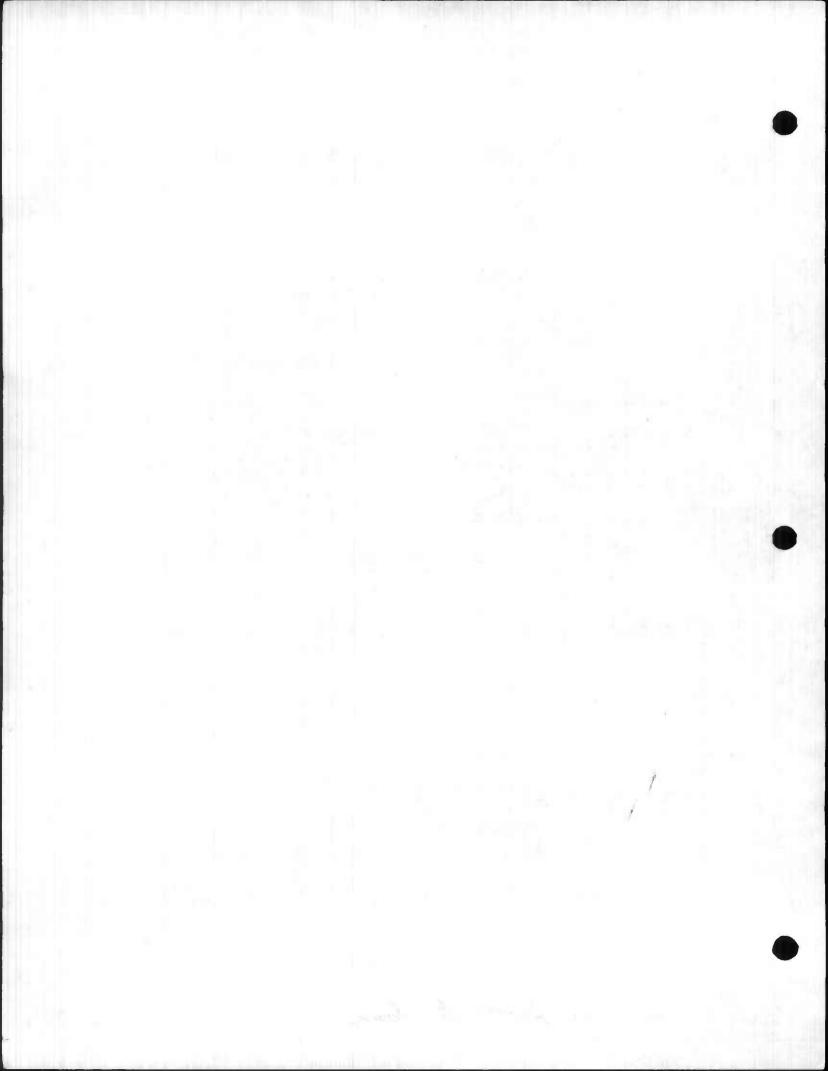
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and dua to the cause(s) and manner stated. edical 29e. Certifier To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054195 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) National Naval Medical Center Anne T. Fox, IT, MC, USNR
31. Date filed (Month, Day, Year) 32. Registrar's Signature Bethesda, MD 20889-5600 State MAR 2 8 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Veer Physician BARBARA **JEAN** BLADEY JANUARY 27,2000 7:14 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert Hours Min. June 25 1921 9. Birthplace (State Mours) Min. June 25 1921 Michigan If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Funeral 10M 20xF Days Months 78 Yrs. 380 20 0340 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert Solomons 1 Yes 2 No Director r than "natural", or items 23s or 28s-f the Medical Examiner must be notifie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? É United States 414 Epworth Court Box 528 20688 Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian Bleck, White, etc. o filed within 72 hours after if Hygiene. other than "natural", or its 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Specify: White Baitimore, Maryland 21215-0020 1 Yes 2X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physcial Therapist Héalth Care permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Nem 27 is married oth any Injury or other traumatic swent and any Injury or other traumatic swent and any Injury or other traumatic swent 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) å Jay Brink Bertha Roskam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen A. Bradey- son/ POA 6611 Mountain Church Rd. Middletown, Maryland 21769 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, Stete completely, cremetory or other place)

Metropolitan FuneralService 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name end Address of Facility Rausch Funeral Home PA 4405 Broomes Is. rd. Port Republic mD 2067 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical 3 days Examiner Examiner physician and the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Box 68760. an/Medical that initiated events resulting in death) Last Due to (or es a consequence of): 907 3 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Physi 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate has 20 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospitel: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 흥 28a. Date of Injury (Month, Day Year) 27. Manper of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: al or Attending Pater death.
I Director: After id in by the funer After 1 DNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c, License number 29d. Dete signed (Month, Day, Year) 29b. Signature and tide of certifier 3306 00 person who completed cause of death (Item 23a) (Type, Print) SYLVIA B. BATONG, M.D., LUSBY, 20657 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 1 2000 Registrar oaks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 4 7 7 |

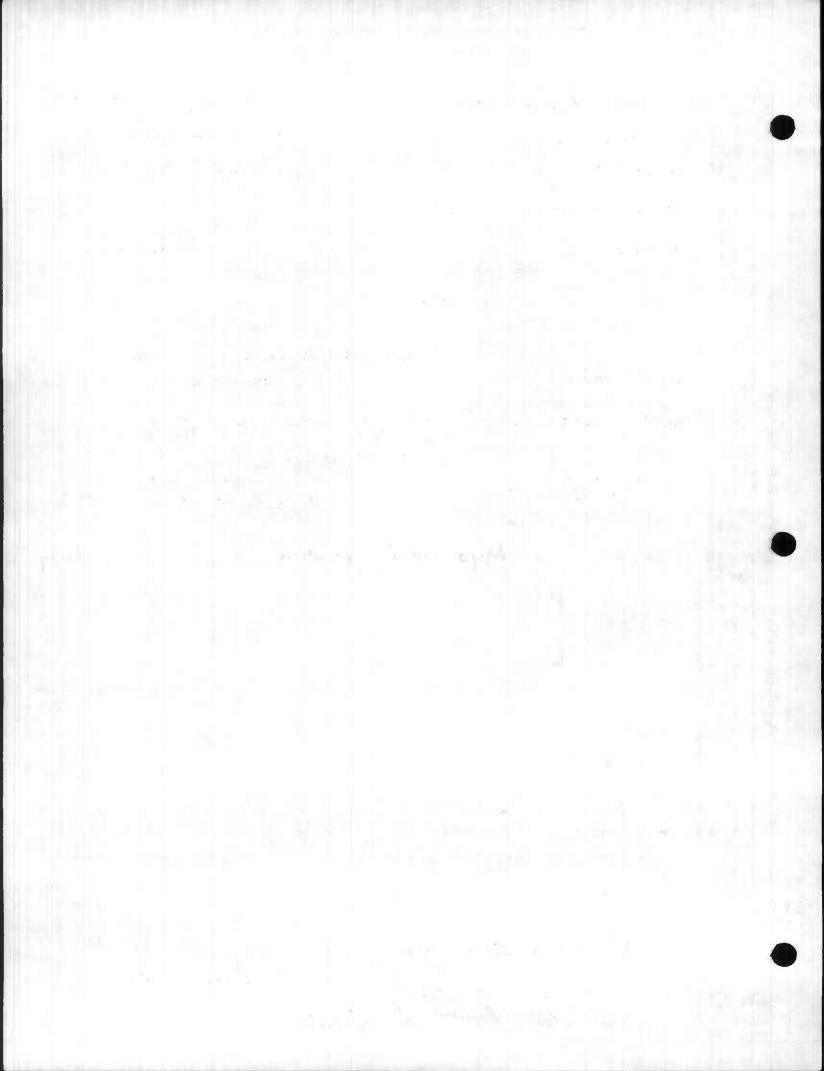
Certificate of Death

	Certificate of Death	Reg. No.
Physician	1. Decedent's Name (First, Middla, Last) Rohert Brooks	2. Date of Death Month Day Year 3. Time of Death
/Medica	Robert	January 24, 2000 6:00 A.M.
Examine	Magnolia Center Lar	own, or Location of Death 1
Funeral Director	5. Social Security Number 213-90-8302 Usual Residence of Decedent 6. Sex 1 1 2 F 7. Age (In yrs. last birthday) 41 Yrs. 7. Age (In yrs. last birthday) 41 Yrs. Hunder 1 Year If Under 1 Year Hours	24 Hrs. 6. Date of Birth (Month, Day, Year) July 13, 1958 9. Birthplace (State or Foreign Country) Maryland
Maryland H show Sed.at	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
death with the Maryland erms 23s or 28s-f show ermust be notified at		10g. Citizen of What Country? USA
_ 1 2 2	3 ☐ Widowed 4 ☐ Divorced Year or Detes:	P1 col-
15-0 72 ho	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mo:	16b. Kind of Business/Industry
2121 ed within ygjere. er than	Elementary/Secondary (0-12) College (1-4or 5+) Iiia. DO NOT use retired) Painter	Self Employed
d gag		er's Neme (First, Middle, Maiden Sumame)
land be lid be l	Roosevelt Brooks Ma	rie Chase
Maryland 21215-0020 and 2 should be flied within 72 hours at alth and Mental Hygiene. 27 is immissed other than "natural, or in traumatic event, the Medical Example To B. Commissed Street Street To B. Commissed Street	19e. Informent's Name/Ralationship (Type, Print) Gladys Woods/Sister 19b. Mailing Address (Street and Numb	per or Rural Route Number, City or Town, State, Zip Code) Dr. Capitol Heights, MD 20743
Saltimore, semit. Pages 1 a superment of Her mportant: if Item my Injury or other ESS.	20a. Mathod of Disposition 1	Data 20c. Location - City or Town, State ry 1/29/00 Huntingtown, MD
Balt permit. Departimental importal any loll angel	21. Signature of Funeral Service Licensee 22. Name and Address of Facil 24. Dares Beac	No. Prince Frederick, MD 20678
Cota be executed by State of the Purision of t	Immediata Cause (Final disease or condition resulting in death) a. Myocadal Tyfoction Dua to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	5 Minutes
6876(ficeta be physicia the burn	Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):	
death death ad for u	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part	23b. Did tobacco use contribute to the cause of death?
P.O. de true de de contra		1 Yes 2 No 3 Probably Unknown
2 3 2 5		24a. Wes an autopsy performed? 24b. Wera eutopsy findings available prior to completion of cause of death?
- F 64 0		1 ☐ Yes 2 No 1 ☐ Yes 2 No
Of Vital Physicien: The tribit certificate and director, per	examiner? Hospital: Hospital: Other: Othe	e of Deeth (Check only one) ursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Physer this sent di	A. The imparient 2 de 1700 de 1800 A. S.	28d. Describe how injury occurred
Division o To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Madical Cartification:	1 Natural 5 Pending (Month, Day Year) Injury Work?	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Div To the Hospital or A within 24 hours after within 24 hours after completely filled in by Madical Cartif		nd place, and due to the cause(s) and mannar as stated.
he Hospi in 24 hou he Funer pletely fil	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, detailed.	ath occurred at the time, data and place, and dua to tha cause(s)
To the Common	1/1/1 MID MO 04760.	-/
-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WINTAM DUBOYCE, MO 4000 MHelhell ville R	d. B216 Bowie, mo 2016
State Registrar	31. Date filed (Month, Day, Year) 12 Registrer's Signeture 12 April 19 Ap	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death **Physician** January 31, 2000 16:58 Kenneth Foster Gerard, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince Frederick Calvert Calvert Memorial Hospital 5. Social Sacurity Number 7. Age (In yrs. last birthday) If Undar 1 Yaar 8. Deta of Birth (Month, Day, Sept 25 9. Birthplace (Stata or Foreign County) Mary Land **Funeral** 1 QM 2□ F Months Days Hours Min 1913 Yrs. 214 05 7544 86 **Director** Usual Rasidance of Decedant with the Maryland 10a. Stete 10c. City, Town or Location 10d. Insida City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Maryfan neart of Health and Mertall Hygiene. Int: If them 27 is marked other than "netural; or frema 23a or 28a-f show ury or other traumatic event, the Merical Experiment ment to notified an ury or other traumatic event, the Merical Experiment ment for notified and Maryland Calvert St. Leonard 1 Yes 2 No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20685 1570 Laurel Road United States Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Raca - American Indian, Black, Whita, atc. 11. Meritei Status 1 ☐ Yas 2 ☐ No If ¥es, Giva Yaar or Datas: 1 ☐ Naver Marriad 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced WWII 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Bustnass/Industry Collega (1-4or 5+) Elamantary/Secondary (0-12) owner/ auto dealership Automobile 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be Edgar E. Gerard Nettie June Hardy 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Kenneth F. Gerard, Jr. = son 5478 Boehm Dr. Fairfield Ohio 45014 20b. Place of Disposition (Name of cematary, cramatory or other plece) Feb St. Paul UMC Cemetery 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 2000 Lusby, Maryland permit. Page Department of Important: if any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Fecility 21. Signeture of Funeral Sarvice Licansea Rausch Funeral Home PA 4405 Broomes Is. rd. Port Republic mD 20676 23a. Part 1. Enter the disaasa, or complications thet caused tha death. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. Approximata Intervel Between Onset and Death **Physician** Immediete Causa (Final diseasa or condition rasulting in death) /Medical lduy Myo condial **Examiner** Examiner ettending physician and for use as the bunal-transit requires that the deeth certificate be executed Sequentially tist conditions, if any, laading to immediate causa. Entar Undarlying Causa (Disease or injury that Initieted avants rasulting in daath) Last Due to (or es a consequence of): Box 68760. Physician/Medical Dua to (or as a consaquance of): 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Nunknown by 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? Completed complation of causa of death? page 2 s 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminar? Be 26. Place of Death (Check only ona) Hospitat: 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 ► Inpetiant 2 ER/Outpatient 3 DOA 28a. Data of tnjury (Month, Day Year) funeral 27. Mennar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Panding 1 ☐ Yas 2 ☐ No investigation 2 Accidant after deat 6 Could not be dataminad Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicida Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 Homicida 24 hours 🔀 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, and due to the causa(s) and manner as stated. 29e. Certifiar edicai 2 Medical Examiner: On the basis of examination end/or trivastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of cartifier Feb 1, 2000 harles W. Bennett M.D. D 25156 30. Nama and address of person who completed cause of deeth (Itam 23a) (Type, Print) Lusby, Md 20657 31. Data filed (Month, Day, Year) W. Bennett Signature. State

DHMH 16 Rev 6/95

Registrar



State S Registrar

31. Data filed (Month, Day, Year)

JAN 3 1 2000

Server

JAN 3 1 2000

30. Name end address of person who completed causa of daath (Item 23a) (Type, Print)

mil) 111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

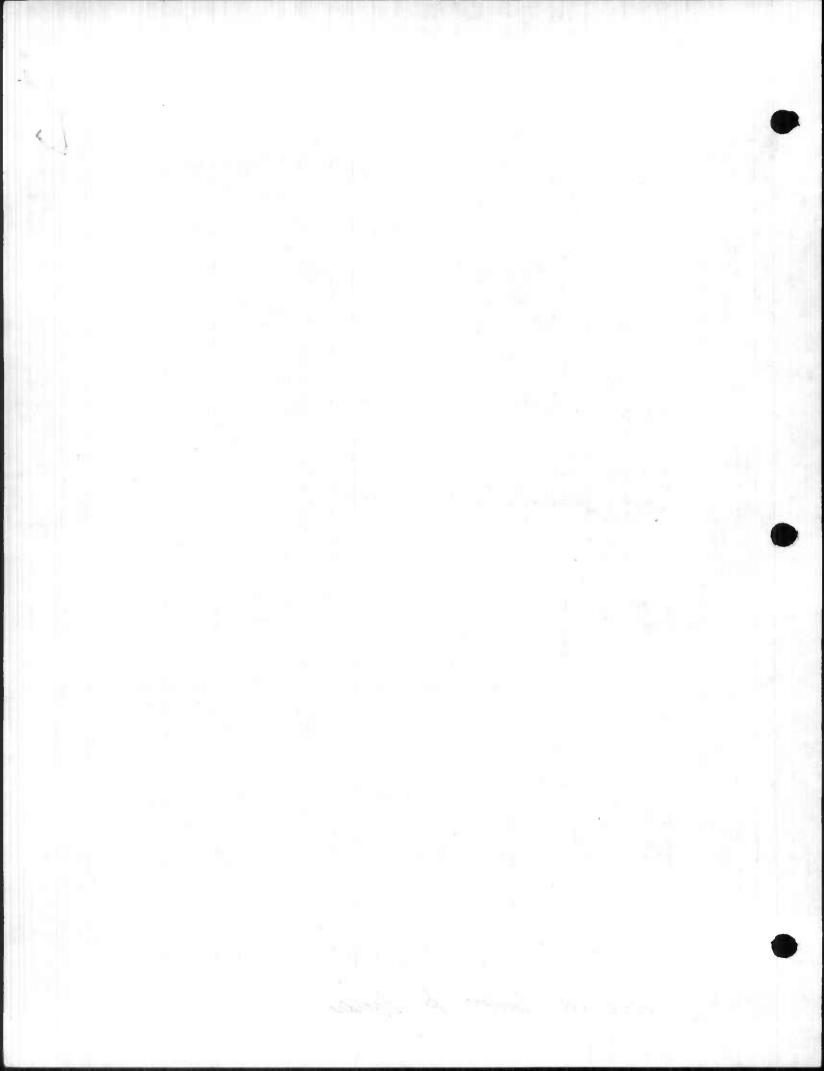
JANUARY 23, 2000

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			_		State	of Ma	arylan				lealth a Death	nd N	lental Hy	giene Reg. No.	J UL;	114	
П	Physiciar		1. Decedent's Name (First, Mide	dle, Last)								2. Date of De Month	eth Day	Year	3. Time of Death	
	/Medica	ıl -	ELMER 4a Facility Name (If not instituti	ion ohio	atreat and a	umbael			H	ANG		en or le	JANUA		2000 nty of Death	09:55	an
A	Examine	r	CALVERT MEMOR										EDERICK		VERT		
	Funeral Director		5. Social Security Number 177-09-9539	6. Se		-	e (In yrs. 86	last birthday) Yrs.	If Under Months		If Under 2 Hours		8. Date of Bir (Month, Da NOV • 26	44.	9. Birthpla	ce (State or Foreig YLVANIA	חן
-			Usual Residence of Decedent											,			
	ahov	5	10a. State 10b. Count MARYLAND CALVI	•			44	y, Town or Lo KIRK	cation						10	d. Inside City Limits	
	the h	2	10e. Street and Number						10f. Zip	Code				10g. Citizen o	of What Countr	v?	
	Mith		11605 JESTER W	AY					20	754				U. S	S. A.		
20	. 0 .	-	11. Maritel Stetus 1 □ Never Married 2 反 Ma 3 □ Widowed 4 □ Divorce	arried	12. Was De Armed F 1 Yes If Yes, G	orces?			Was Deced 1 Yes, spec		lispanic Orig an, Mexican, Specify:	in? (Sp Puerto	ecify Yes or No Rican, etc.)	14. R 8	ace - America lack, White, el	c.	
9	netural,		15. Decede		Year or l	Dates:		16a. Deced	lent's Usu	ei Occup	ation		,	16b. Kind of	Business/Indu		_
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Maryland	d be fill he fill he doth	10 26	17. Father's Name (First, Middle JOSEPH HANGE	e, Last)									e (First, Middle TH RUTH		ame)		
	d 2 sh th and 7 ie m traum		19a. informant's Name/Relation RUTH HANGE /						_				RK, MAR	-	on, State, Zip (20754	Code)	
Baltimore,	8 9 7 7		20a. Method of Disposition 1 Buriel 2 □ Cremetion 4 □ Donation 5 □ Other (n State	C	Place of Dispo semetery, cren ERDALE	natory or o	ther plac			FEB. 2,2000		n-City or Tow Maryla		
Balti	permit. Pag Department important: I any injury o		21. Signature of Funeral Service	Ligens	90	9		22	Name an	d Addre	ss of Facility	LEE	FUNERA	L HOME	CALVEF	T,P.A. D 20736	
	Physician /Medical Examiner	Jer	Immediate Cause (Final disease or condition resulting In death)	at only o		Н	Ron	JIC O		RUC	TIVE	fl	LLMONI	CRY DI		Merval Between Onset and Death	
,	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ſ	b		Due to (o	or as a conseq	uence of):						t		
Box 68760,	ate be hysicia the bur	rnysiciarymedical	Cause (Disease or Injury that initiated events resulting in death) Last	ĺ	d		Due to (o	r as a conseq	uence of):						l t		
	0 0 0	SICIE	Part ii. Other significant condit	iona co	ntributing to	death bi	ut not res	ulting in the u	nderlying o	ause giv	en in Part I.		23b. Did	tobacco use	contribute to	the cause of death	h?
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of Vital Records,	W S S	besed												an autopsy ormed?	avai	e autopsy findings lable prior to ipletion of cause eath?	
œ	The lay												10	Yes 20 No	10	Yes 2□ No	
Vita	s certificate director, pag	0	25. Was case referred to medic examiner?	-	do enited.	,				100		of Deet	h (Check only	one)			
of	this ral di		1 Yes 2 No 27. Manner of Death		lospital: 152	Inpatie	7	ER/Outpatien		-	4 LI NUI	rsing Ho	ome 5 Resi				_
on	After fune	LOD	1 Natural 5 Pend	ling tigation		nth, Day		injury	м	8c. Injur Wor 1 🗌	rk? Yes 2□h	No	200.00	non aquity out			
Division	tal or Attending P rs after death. al Director: After t led in by the funera	erillica	3 Suicide 6 Could	_			ury - At ho	ome, farm, str	eet, factor	y, office				(Street and Nu wn, State)	mber or Rural	Route Number,	
	Hospi 4 hou Funer tely fill				ner: On the		examina						end due to the red at the time,				
	To the To the comple		29b. Signature and Alle of certif	ier	<i>x</i> .	,			29	c. Licens	se number			29d. Date sig	ned (Month, D	lay, Year)	
			file	//	W	n	- 1	20	1 7	040	2370	2		1/2	-7/00		
			30. Name and address of perso	n who co	ompleted cau	use of d	eeth (Iten	n 23a) (Type,					1		1		
			DR. PETER W		IEWSK	XI,N	1D	PRINC	E FR	EDR	ICK,	MD	2067	8			
	State Registrar	•	FEB 0 1 20	00	Sep.	Hegista	ars Signa	ر . ال	pour	6							

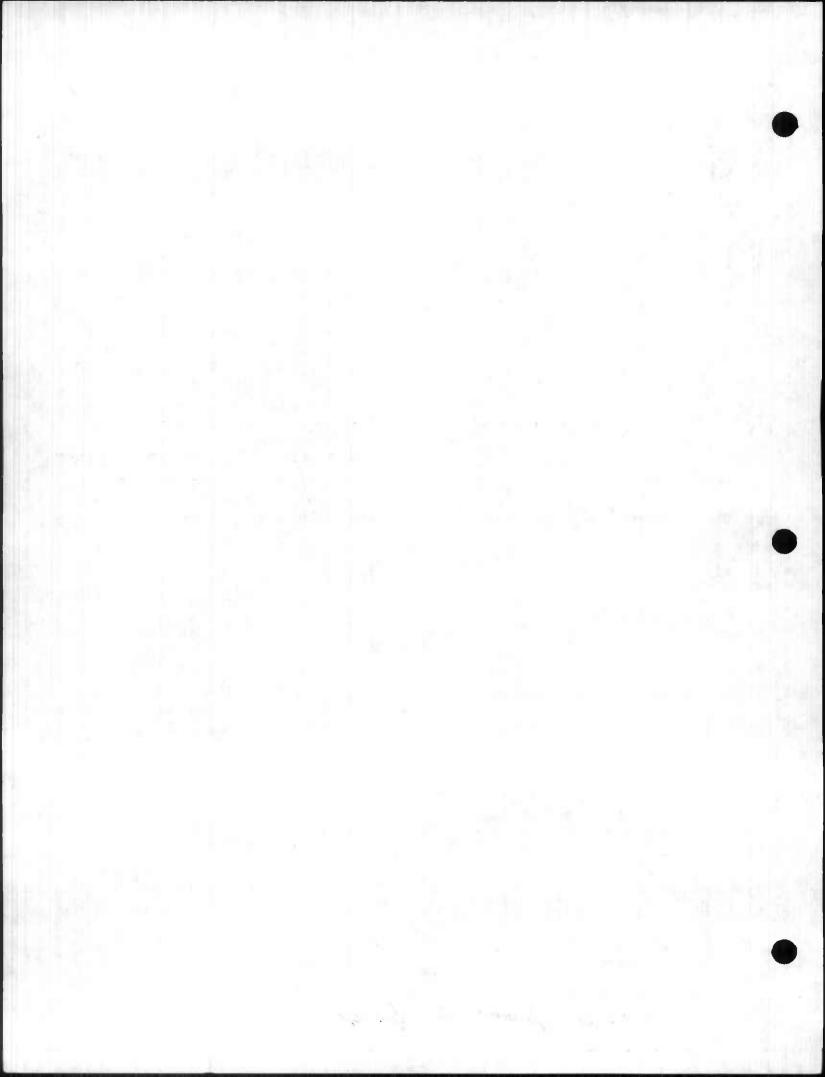
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tate of Maryland / Department of Health and Mental Hygiene	U	U	UH	11

			Cei	tificate o	f Death		Reg. I	No.		
	1. Decedent's Nama (First, Middle, La	st)					of Death			3. Tima of Death
Physician	Joseph Jay	Hatfield, J	r.			Jan	uarv		9ar 000	07:03 A.M
/Medical Examiner	4a Facility Name (If not institution, giv				4b. City, Tov	vn, or Location of	-	4c. County of		07.03 11.11
LAdillilei	Prince Georg	e's Hospital C	enter		Che	everly		Prin	ce G	eorge's
Current	5. Social Security Number 6. S			If Under 1 Ya	1		of Birth			
Funeral Director		Øм 2□F 17	Yrs.	Months De	ys Hours	Min. Feb	of Birth th, Dey, Ye . 25, 19	982 Wa	Shi	ngton, DC
the Maryland c 28a-1 show motified at frector	10a. State 10b. County Maryland Calvert	10c. City Owi	r, Town or Lo	cation					10	d. Inside City Limits 1 ☐ Yas 2 ②No
or 25a-f.s be notified Directo	10e. Street and Number	OWI	iigo	10f. Zip Cod	A		10a	Citizen of Who	nt Count	N?
E 22 D	1737 Candlestick			2073	6			U.S.	A.	
hours after death vibral, or thems 23 at Examiner must be by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Datas:		Was Decedent of Yes, specify C	uban, Mexican,	in? (Specify Yes Puarto Rican, at	or No- c.)	14. Race - Black, Specify:	America Whita, e	tc.
72 hours natura dical E	15. Decedent's Ed	lucation	16a. Deced	lent's Usual Oc	cupation	a formately a	16b	. Kind of Busin		
ad within 72-ho vgieno. ver than "naturi it, the Medical. Completed	(Specify only highast gra Elementary/Secondary (0-12) 12	College (1-4or 5+)	Stude	kind of work do OO NOT use rel	ne aunng most lired)	or working	H	igh Sch	Loon	
Co President	17. Fethar's Name (First, Middle, Last)		Duac		19 Mother	's Name (First, N			1001	
Maryland 21215-0020 62 should be filed within 72 hours at h and Merical Hydinasi Hydinasis Hydinasis Hydinasis Control traumatic event, the Medical Examp To Be Completed by F	Joseph Jay Hatfi					net Mari				
Z sho Z sho z sho z sho z sho	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stre	eet and Numbe	r or Rurel Route I	Vumber, Cit	ty or Town, St	ete, Zip	Code)
C 70 00 4c	Janet M. Hatfield	/ Mother	1737	Candles	stick Wa	ay Owing	s. Ma:	rvland	20	736
of Heart of	20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Neme of netory or other)	n/aca)	Date		Location - Ci		
Pag ment: If ury o	12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Sou	thern	Memoria	al Grdns	Jan. 29,20	00 D	UNKIRK		
Demit. Depart Import any in	21. Signature of Funeral Service Licer	1000	81	Name and Ad	dress of Facility Thern MI	Lee Fun	eral l Owing	Home Ca s, MD	alve 207	rt,P.A. 36
	23a. Part1. Enter the disease, or com- shock, or heert feilure. List only	plications that caused the death	. Do not ent	er tha moda of o	dying, such as	cardiac or respira	tory arrast,			Approximate Interval Between
Medical Examiner used to see the second	Immediate Cause (Finel disaasa or condition resulting in death)	b. Due to (or	es a consequence as e consequence						1 1	
ntificate being physicial as the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest	c	as a conseq						1 1 2	
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sic sed	Part II. Other significant conditions o	ontributing to death but not resu	Iting in the u	nderlying ceuse	given in Part I.	23b	. Did tobac	co uss contr	ibuta to	the cause of death?
es that the death ce igned by the ettend be detached for us, by Physician/					4		1 🗆 Yes	2 No 3	☐ Prob	ably 4 Unknow
The law requires the last been signed page 2 should be Completed by						24a	. Was an au		ava	re autopsy findings ilable prior to apletion of cause eath?
The j							1 XXes	2 No	1,5	Yes 2□ No
certificate irector, pa	25. Was case referred to medical				26. Place	of Death (Check	only one)			
Physician: this certific ral director. To Be	examiner? 1]X] Yes 2 ☐ No	Hospital: Napatient 2 1	ER/Outpatien	t 3 DOA	Other:	rsing Home 5		6 □Other	/Snecify	}
Physeral di	27. Menner of Death	28a. Dete of Injury	28b. Time of		njury at Work?			njury occurred		,
tanding Pheath. for: After the the funeral cation:	1 □ Natural 5 □ Pending 2 ☑ Accident Investigation	(Month, Day Year)	1153		Vonkr ☐ Yes 2 🖼	40 moto	r ueh	icle a	ccid	ent
	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, ferm, str		СӨ	City	ition (Street or Town, St field	1010) Ferry	Lan	Route Number
Hospi 14 hours Funar tely till		yelclan: To the best of my know where: On the basis of examinati	vledge, death	occurred at the		plece, and due t	to the cause	e(s) and mane	er as st	
To the within 2 comple	29b. Signature and title of certifier	and manner stated.	-	29c. Lic	ense number		29d.	Date signed (Month, L	Day, Year)
	1	Charts			O.C.M.E	5.		January	7 24	2000
	30. Name and address of person and	completed cause of death (Item	23a) (Type,		0.0.17.1			Januar	24	2000
	Dennis J.	Chutero		1 Penn	Street,	Baltim	ore, l	Marylar	nd 2	1201
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrar's Signal	ure	parker						



January 24, 2000

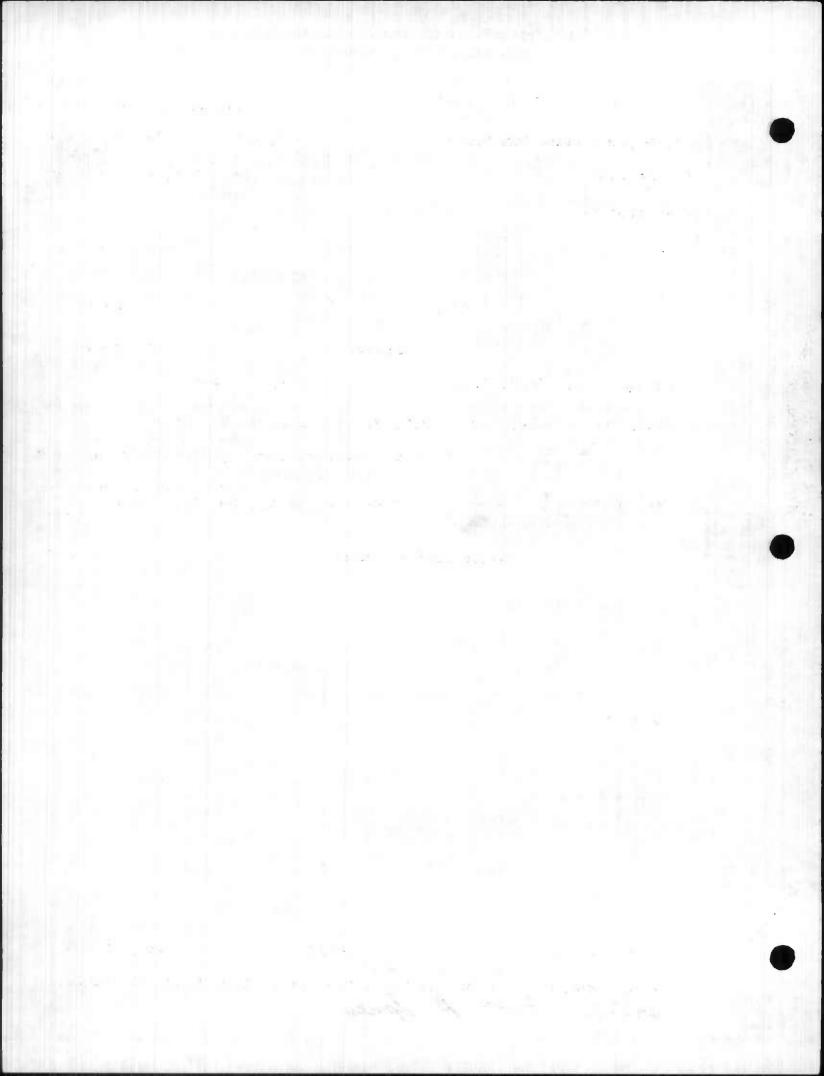
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Examiner	4a Facility Name (If not in						1	4b. City, To			Death	4c. County		
	VA Maryland					. If I lade	er 1 Yaar	Per If Undar		oint	7 Ph 1 Al			
Funeral Director	5. Social Security Number 12 28 8735	5	ex IDM 2□F	7. Age (in yr 71	Yrs.	Months		Hours	Min.	Feb	of Birth oth, Day, 17	Year) 1928	9. Birth Cou Ma:	place (State or Foreig intry) ryland
f show find at tor	10a. Stata Maryland C	County		10c. (P	city, Town or erry	Location Point	t							10d. Inside City Limit
or items 23s or 23s-f show uniner must be notified at Funeral Director	10e. Street and Number Ward 25 B						ip Code 1902	}				Og. Citizen of V Unite		
9 6	11. Marital Status 1 X Nevar Marriad 2 3 Widowed 4 D		Armed F	cedent Ever in corces? 2 No live Dates: 50-		3. Was Dece If Yes, spe 1 \(\subseteq \text{Yas} \)		lispanic Or an, Mexica Specify		pecify Yes o Rican, e	or No-		ck, Whita	ican Indian, , atc.
dical E	15. E	Decedent's Ed			16a De	cedent's Usu	uel Occup	ation	st of wor	rkina	1	16b. Kind of B	usiness/li	ndustry
t, the Medical I	Elemantary/Secondary			(1-4or 5+)		ive kind of w 9. DO NOT arente		d)		9		const	ruc	tion
To Be C	17. Fether's Name (First, George Ht			Sr.						ne (First, i		Aaiden Surnan	n <i>e)</i>	
-	19a. Informant's Name/R	lelationship (Type, Print)										State, Z	ip Code)
ž.	Miriam Phippin- sister P.O. Box 504 Hebron, MD 21830													
If them 27 or other tr	20a. Method of Dispositio		Removal from State St. Paul Cometery Jan 2									20c. Location OOLush		
ortant: If injury or	4 Donation 5 C	Other (Specif	(א	St	. Pau	22. Name a			itv	-				
al er	4 Donation 5 0	Other (Specifical Service Licer	plications that one ceuse on	caused the de	eath. Do not	22. Name a 1405 enter the mo	Brocode of dylr	ss of Facil	Is.	Raus	ch F	Funera	al H	ome PA lic MD Appropriate 6 Interval Between Onset and Death
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Registrar

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

D42411

NAME KNOWN TO PHYSICIAN:



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Year **Physician** DORIS MARIE JONES 31, JANUARY 2000 2035 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Prince Frederick Calvert Memorial Hospital Calvert H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth Months | Deys | Hours | Min. | July 19, 1923 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Yrs. 213-42-6243 Director Usual Residence of Decedent 10d. inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 Yas 2 No Directo Owings Calvert 289-1 Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Norma 23a 20736 USA 8010 N. Solomons Island Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Black. Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be little within 1 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "s any injury or other traumetic event, the Mag Elementery/Secondery (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumama) Be Lydia Watkins Franklin Otha 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Owings, MD 20736 Emerson Road Box 83 Kevin Jones/Son 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burlel 2 □ Cremetion 3 □ Removel from State 2/4/00 Cooper's UMC Cemetery Dunkirk, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme and Address of Fecility Sewell Funeral Home 21. Signature of Funerel Service Licensee 1451 Dares Beach Rd. Prince Frederick, MD 20678 Approximate Intervel Between Onset end Deeth 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final encephalopathy disease or condition resulting in death) Examiner 4-5 days Due to (or as a consequence of): Examiner pers physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) for use as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? degeneration ē Quadriplogia 3 Probably 4 Unknown otropuntocerebellar 1 ☐ Yes 2 ☐ No Division of Vital Records. þ should be d Completed 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No certificate Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 1 Netural 2 Accident 5 Panding s after death. 1 Yes 2 No investigetion 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Hospital 29e. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and plece, and due to the ceuse(s) and menner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. Vithin 2 To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lalunyowsen D0027189 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Dey, Year) FEB 0 2 2000

ZAHIR YOUSAF

P.O. 32. Registrar's Signeture

WALDORF, MO.

20604-1289

1289

BOX

NA THE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month James Dorsey JONES, January 26 2000 7:30 p.m. 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1₩ 2□ F Months Min 577 52 7825 63 July 23,1936 Owings, Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Calvert 1 Yes 2 No Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12193 Cavalier Drive 20754 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☑ Yes 2 ☐ No 1 Never Merried 2 Merried 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 1956-58 white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) automobile parts manager auto dealership 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roswell Cornelius Jones Bessie Irene Brady 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Elizabeth Jones/wife P.O. Box 82, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) Mt. Harmony Cemetery 01-29-00 Owings, MD 20736 21. Signeture of Fugeral Service Licensu 22. Neme end Address of Facility

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f

matthe b

therma:

8

Hygiene.

Pages 1 and 2 should be the ment of Health and Mental H aut; if them 27 is marked oth tary or other traumatic even

Director

Funeral

à

Completed

Be

The Marviand

filed within 72 hours after

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed

has

certificate

this

After

24 hours after death.

Funeral Director: A

within 2 To the F

Hospital

the the

10+1

Box 68760.

P.O.

Records,

Division of Vitai or Attending Physician:

burial-transit physician the buna 88 for USB a signed by the e page 2 1 funeral filled in by

Examine Physician/Medical þ Completed Be Certification: To

Medical

27. Manne of Death

Immediate Cause (Fine) disease or condition resulting in deeth) Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Yes 2 No

5 Pending

investigetion

6 Could not be determined

1 Neturel

2 Accident

3 ☐ Suicide

4 Homicide

23a. Part 1. Enter the disease, or comshock, or heert failure. List only

Due to (or as a consequence of)

Due to (or es a consequence of) Due to (or as e consequence of):

26. Place of Death (Check only or 25. Wes case referred to medical axaminer? Hospitel: Other

1 [Inpatient

1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed?

23b. Did tobecco use contribute to the cause of death?

1□ Yes 2□No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Approximeta Interval Between Onset end Death

09

0. 1 M200 OI DO	aur jos	DON CITY CITY	
4 Nursing F	lome	5 Residence	6 Other (Spec
	28d.	Describe how inju	ury occurred

Rausch Funeral Home, P.A., Owings, MD 20736

28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury a Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. onel 29b. Signative 29d. Date signed (Month, Day, Year) and title of ceptities

2 ER/Outpatient 3 DOA

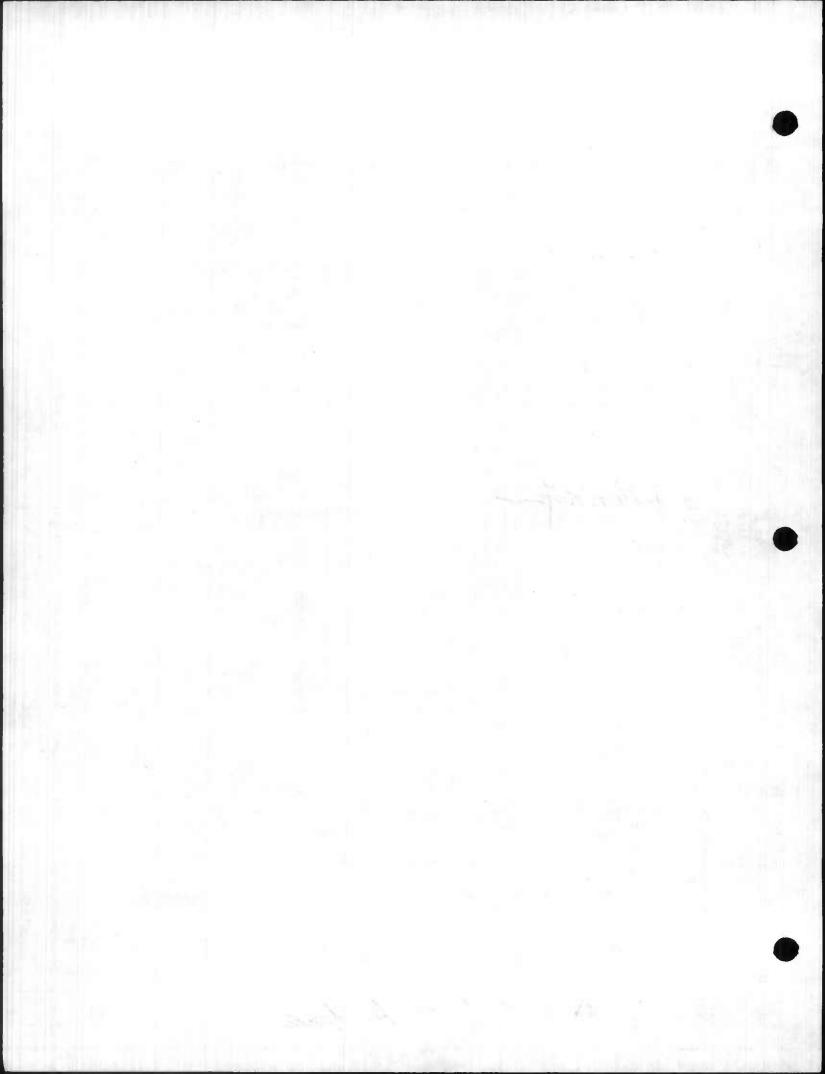
ilications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line.

completed cause of death (Item 23a) (Type, 1770t) 30. Neme and address of person who 6 H

KU

State Registrar

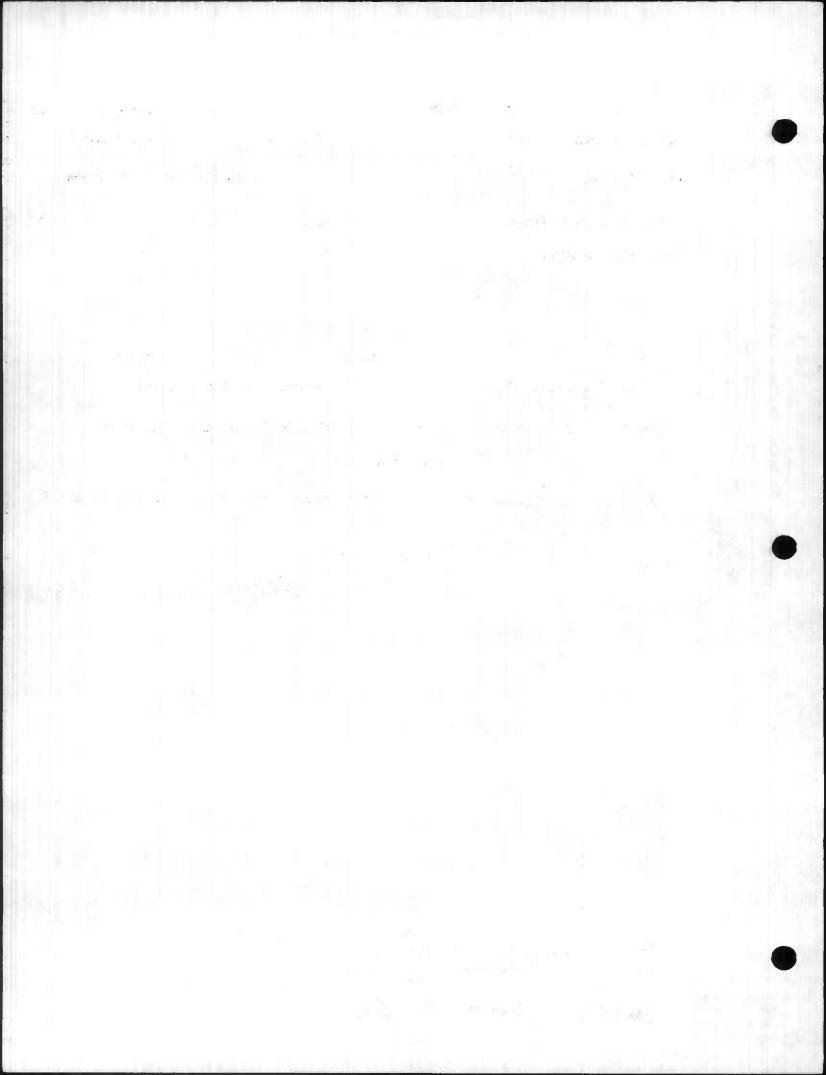
ava 31. Date filed (Month, Day, Year) 32. Registrer Signeture 8 2000



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

December Physician Accident Physician Physician Accident Physician Physic			,	Certificate of Death	Reg. No.	04779
VERA REBY January 2 2000 9:00 p.m. Andelica for Facility Name (and crastificing higher from the first passage and number) Fruncal Director. Fru			Decedant's Nama (First, Middla, Last)	2.		3. Time of Death
Second Part Country		•	VERA REBA KERB	Y J.		9:00 p.m.
Bradford Oaks Nursing Hone Funct Function Special 1		4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or Locat			
State Stat			Bradford Oaks Nursing Home	Clinton	Prince Ge	eorge's
Second Prince Georges 10c. City, Town or Location 10d. reject City Town or Location 10d. Taylor Code 10d. Taylor Co			577 20 0160 1DM 2NF 89	Months Days Hours Min.	(Month, Day, Year) C	
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Elementer//Secondary (0-12) College (1-4or 5+) Infe. DO NOT use retired) Nomemaker Own home		the Mary 28a-f sh cottled			10g Citizen of What C	45
Elementer//Secondary (0-12) College (1-4or 5+) Infe. DO NOT use retired) Nomemaker Own home		23a or	7520 Surratts Road	20735	USA	
Elementery/Secondary (c-12) College (1-4or 5+) Infe. DO NOT use retired) Nomemaker Own home	0000	ours after de rel', or item Example: 1	1 Never Merried 2 Married Armed Forcas? 1 Yes 2 No If Yas, GNa		en, atc.) Bleck, Whi	Ite, atc.
Physician / Medical Examiner 23a. Part. Enter the disease, or some cations that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, inflavral Batween Onset and Day in June 1997. The mode of Causa (Fine) disease or condition resulting in death) 25a. Part. Enter the disease, or some cations that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, inflavral Batween Onset and Day in June 1997. The mode of Causa (Fine) disease or condition resulting in death) 25a. Part. Enter the disease, or some cations that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, inflavral Batween Onset and Day in June 1997. The mode of Causa (Fine) disease or condition resulting in death) 25a. Part. Enter the disease, or some cations that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, inflavral Batween Onset and Day in June 1997. The mode of Causa (Fine) disease or condition resulting in death) 25b. Due to (or as a consequence of): 27c. The mode of Causa (Fine) disease or conditions, if any leading to mine distance of the cause of Causa (Fine) disease or conditions, if any leading to mine distance of the cause of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions, if any leading to mine distance of Causa (Fine) disease or conditions or causa (Fine) disease or conditio	5-0	72 h natur		Decedant's Usual Occupation (Giva kind of work dona during most of working)	16b. Kind of Business	s/Industry
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30. Name and eddress of person who completed cause of death (Itam 23a) (Type, Print)			30. Name and eddress of person who completed cause of death (term 23a	() (Type, Print)	7 7 3	1, 2000
L. Berwa, M.D. 7700 Old Branch Ave., Clinton, MD		6	/		nton, MD	
State Registrar JAN 2 7 2000 Security Signature Aparts Signature		State	31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature	/		

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month JANUARY 22, 2000 0545am MARGARET KATHLEEN HOTCHKISS MOLLENHAUER 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 2646 Aster Road Port Republic Calvert 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Days Hours 1 M 2 ₩ F Yrs. 224 32 0836 April 3, 1909 Texas Usual Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. fnside City Limite Alexandria 1 N Yas 2 No Virginia Fairfax 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22309 United States 3704 Carriage House Court 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ā Year or Datas: 14. Race - American Indian, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 □ Naver Married 2 □ Married 1□ Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Secretary Hospital 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Lenora Viola Avenette Archibald Duncan Hotchkiss 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 22309 19a. Informant's Name/Relationship (Type, Print) 3704 Carriage House Court, Alexandria, Virginia Mary Beasley/ Executrix 20a. Method of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or Town, State Mission Burial Park South 1/27/00 San Antonio, Texas 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. ailes F. Bell 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disaasa or condition resulting in death) ears Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaasa or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yee 2 No 3 Probably 4 SUnknown 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Department of smooth or any injury or Injury or

Physician

/Medical

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Funeral

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Completed

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Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours efter onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iter

Baltimore, Maryland 21215-0020

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death

physician and the buriel-transit 98 980 page 2

Examiner Physician/Medical by Completed Be 0 Certification:

the death certificate be exec signed by the a certificate Attending Physician: this unerel After ofter deetl filled in by

Division of Vital Records, P.O. Box 68760,

25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Dascribe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding 1 Yes 2 No invastigation 2 Accidant 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifiar 1 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, date and place, and due to tha causa(s) and mannar as stated

29b. Signatura and title of certifier

(Check only one)

JAN 27

2000

29c. Licansa number

048314

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s)

29d. Date sloned (Month. Dav. Year)

122

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

Paul V. Pomilla, M.D. Prince Frederick, MD 20678 31. Data filed (Month, Day, Year)

and manner stated.

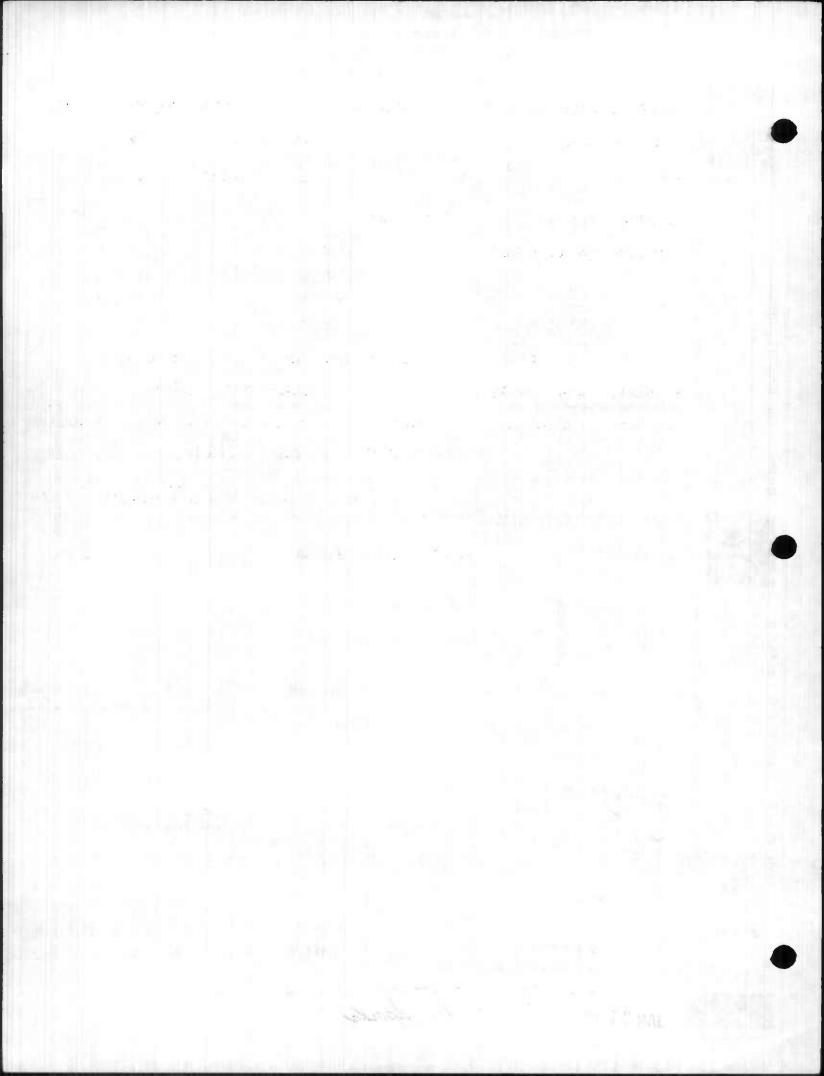
State Registrar

Medical

32. Registrar's Sign

24 hours Funeral

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) January 25 **Physician** Lucille Grover Mackiewicz 2000 SAM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva streat and number) 4c. County of Death Examiner Solomons Nursing Center Solomons Calvert If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth 9. Birthpiaca (Stata or I Country)
Oct 13 1925 Maryland 9. Birthpiaca (Stata or Foraign 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 1□ M 2□F 74 Yrs. **Director** 220 12 2649 Usual Rasidanca of Decedan the Maryland 10b. County 10a. Stata 10c. City, Town or Location 10d. insida City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Marylan tent of Health and Mental Hygiane.
ant: If item 27 is marked other than "natural", or itema 23a or 28a-1 show the traumatic event, the Hostical Example must be nowither to Maryland Calvert Huntingtown 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 24 Robshire Manor 20639 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ê No If Yas, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Black, Whita, atc. 1 □ Navar Married 2 □ Married Specify: White Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuaf Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elamentary/Secondary (0-12) Collega (1-4or 5+) homemaker own home 18 Mothar's Nama (First Middle Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Be Wilber Grover Eva Garner 19a. Informent's Neme/Reletionablp (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Stephen G. Mackiewicz -son 2040 Pappas Lane Lusby Md 20657 Baltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place)

St. Paul Cemetery 28 Data 2000 Lusby Maryland 20a. Method of Disposition 1 Jurial 2 Cramation 3 Ramoval from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funeral Sarvice Licenses 22. Nama and Addrass of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port REpublic Md 2076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximata ntarval Batw Onset and Death **Physician** structive Sever immediate Cause (Final disaase or condition rasulting in daeth) /Medical Examiner Due to (or as a consequence of Examiner saara Sequentially list conditions, if any, leading to Immediate causa. Enter Underlying Ceusa (Disease or Injury Dua to (or as a consequence of) certificeta be exec physician er s the buriel-t Box 68760. Physician/Medical thet initiated events rasulting in death) Last Dua to (or as a consequanca of): 88 980 23b. Did tobacce use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 2 3 Probably 4 Unknown Division of Vital Records. þ 24b. Wara autopsy tindings availabla prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 20 No 1 □ Yes 2 □ No 25. Was casa rafarred to medical axaminar? Be 26. Plece of Death (Check only ona) Hospital: Other: 45 Nursing Homa 5 Rasidance 6 Other (Specify) 1º 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Attending 1 Natural 5 Panding after death. Director: Aft 1 Yas 2 No investigation 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida ò Hospital 24 hours 29a. Cartifian Descrifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signetura and titla of cartifian D 0 D 19427 Jan 27 2000 Alla 30. Name and address of person who completed cause of death (Nam 23a) (Type, Print)

State Registrar

31. Data filed (Month, Day, Year) JAN 2 7 2000

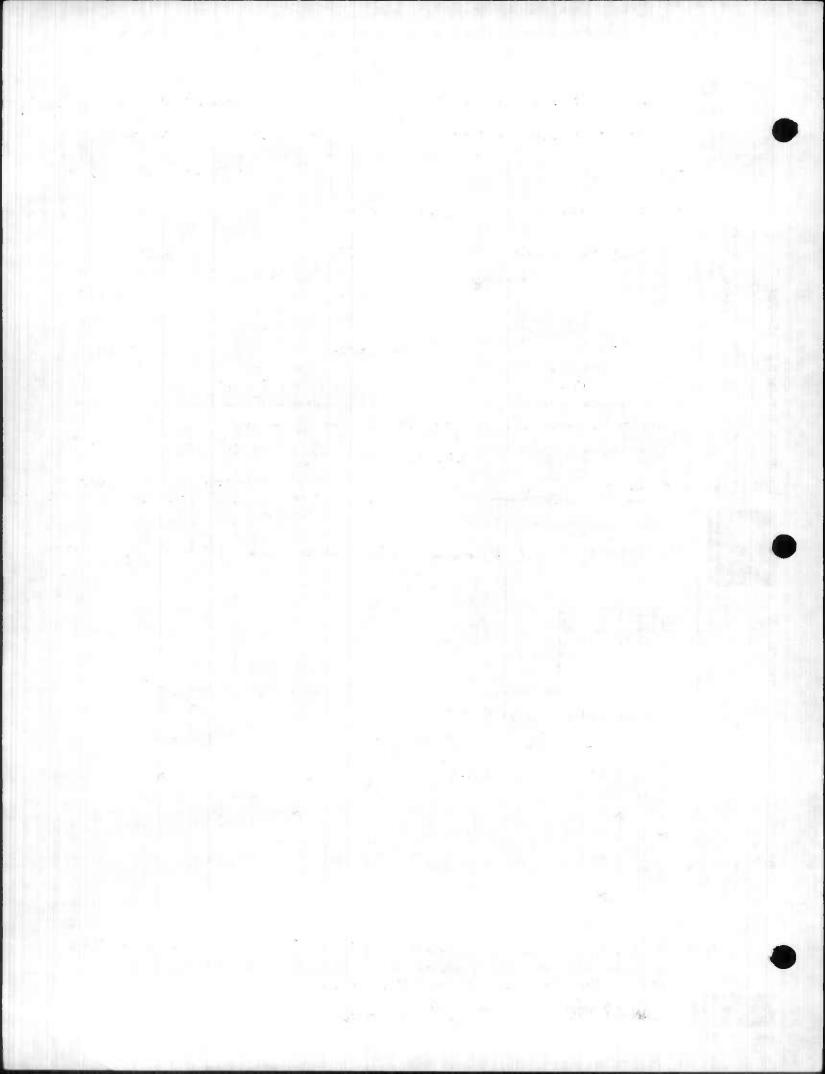
Anwar T. Munshi,

M.D. Prince Frederick, MD 20678

32. Ragistrar's Signature

Localists

Apolls



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Phillips, Sr. 12:30 P.M. 2000 January 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 11710 Millbridge Road Calvert Lusby 6. Sex 1 M 2 ☐ F If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthpiace (State or Foreign Country) Deys 87 Yrs. Nov. 21, 1912 Maryland 10c. City, Town or Location 10d. Inside City Limits Calvert 1 Yes 2 No Lusby 10f. Zip Code 10g. Citizen of Whet Country? 11710 Millbridge Road 20657 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, Whita, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: Black 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuei Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Coilege (1-4or 5+) Waterman Seafood 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Phillips Sarah 19e. intormant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edie Hutchins/Granddaughter 650 Gunsmoke Circle Lusby, MD 20657 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Buriai 2 Cremetion 3 Removel from Stete St. John UMC Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 2/3/00 Lusby, MD 22. Name and Address of Facility Sewell Funeral Home 21. Signeture of Funerei Service Licenses 1451 Dares Beach Rd. Prince Frederick, MD 20678 4 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervai Betw

Onset and Deeth

Physician /Medicai Examiner

Physician

/Medical

Examiner

Funeral

Director

with the Maryland

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "naturel", or hems 23a or 28a-f show way fulury or other traumatic avent, the Medical Examinat to notified at once.

Baltimore, Maryland 21215-0020

Alexander

10b. County

5. Social Security Number

217-07-8907

10a Stete

Director

by

Completed

Be

Maryland

10e. Street and Number

Usuel Residence of Decedent

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondery (0-12)

Alexander

20e. Method of Disposition

immediate Cause (Finei

To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within 42 hours after deeth.

To the Funeral Director: After this certificata has been signed by the attending physician end completely filled in by the Increal director, page 2 should be detected for use as the burnel-transit

Division of Vital Records, P.O. Box 68760,

	resulting in death)	0.	. 0 0 00,000		~~ (
ler	Transfer of the second of the	Due to	(or es a consequence	ot):		
Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or es e consequence	ot);		
Physician/Medical	Cause (Diseese or injury that initialed events resulting in deeth) Last	c	or es a consequence o	of):		
y Physicia	Pert ii. Other aignificant conditions of		suiting in the underlyin	g cause given in Pert 1.	23b. Did tobacco use o	contribute to the cause of death
Completed by	Hrgh bloc	d pressure			24a. Wes en autopsy performed?	24b. Ware sutopsy findings svaliable prior to completion of cause of death? 1 Yes 2 No
0	25. Wes case reterred to medical examiner?			26. Piece of D	eeth (Check only one)	
0	1 ☐ Yes 2 No	Hospitei: 1 ☐ inpatient 2 [☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 Residence 8 0	ther (Specify)
	27. Menner of Deeth 1 Death 2 Naturel 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. injury at Work? 1 Yes 2 No	28d. Describe how injury occi	urred
	3 Suicide 6 Could not be determined	28e. Plece of Injury - At I building, etc. (Spec	nome, ferm, atreet, fec	tory, office	28f. Location (Street end Nun City or Town, Stete)	nber or Rural Route Number,
Medical cel tillcation.	29e. Certifier (Check only one) 12 Certifying Ph	ysician: To the best of my kn niner: On the basis of examin and menner ateted.	owledge, deeth occurr etion end/or investiget	ed et the time, dete and ple ion, in my opinion, deeth oc	ce, and due to the cause(a) and r curred at the time, dete end place	manner as atated. e, and due to the cause(s)
H	29b. Signeture end title of certifier	Bennett M.		29c. License number		ned (Month, Day, Year)

(ecclopoursal Accident

State Registrar

31. Dete tiled (Month, Dey, Yeer) FEB 0 1 2000

Charles a Bennett M.D.

30. Nemo and address of person who completed cause of deeth (Hem 23e) (Type, Print)

Charles Bennett M.D., 11845 Tournan Rd. Lusby, Md. 20657 32. Registrer's Signeture

D25156

April 1 177 P. Spiniter 1 1/1 ------

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 04783 Certificate of Death 2. Dete of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **JANUARY** CLARENCE CARSON THACKER JR. 29, 2000 1:30 AM 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street and number) 4c. County of Death Frederick Memorial Hospital Frederick
If Under 1 Yeer | If Under 24 Hrs. | 8. Frederick 8. Date of Birth 9. Birthplace (State or For Sept. 99. 1954 VII ginia 7. Age (In yrs. last birthday) e (State or Foreign 15 M 2□ F Days Hours 45 Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 XYes 2 No 10g. Citizen of What Country? United States 10f. Zip Code 21701 409 North Market Street 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white UNK 3 ☐ Widowed 4 ☐ Privorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Boatswain Mate 1st class U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Thacker, Sr. Cherry Marie Ogan 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Clarence C. Thacker, Sr.-father 11889 Manoe Ct. Lusby Maryland 20657 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dale 20c. Location - City or Town, State olivet UMC Cemetery 1, 2000Lusby Maryland 1 Duriat 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 2067 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IPPER GastroIntestinal Bleeding Due to (or as a consequence of) 23b. Did tobacco uss contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

The law requires that the death certificate be executed

P.O.

of Vital Records.

Division

grates

Completed by Physician/Medical Examiner

Be

Medical Certification: To

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

217 60 9414

10e. Street and Number

11. Marital Status

10e. State

Usual Residence of Decedent

12

Clarence C.

20a. Method of Disposition

Funeral

Director

28a-f

ns 23a or must be r

8

Maryland 21215-0020

Baltimore,

filed within 72 hours

Pages 1 and 2 should be nent of Health and Mental ent: If Item 27 is marked o

and it

of of Health :

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in deeth)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy parformed?

24b. Were autopsy findings available prior to completion of cause of death?

2 X No

1 Yas 20 No

25. Was case referred to medical examiner? 26. Piace of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No 27. Menner of Death 1 Netural

2 Accident

4 Homicide

3 Suicide

5 Pending investigation 6 Could not be determined 28a. Date of tnjury (Month, Dey Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

281, Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier

29c. License number D41866 29d. Date signed (Month, Day, Year)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

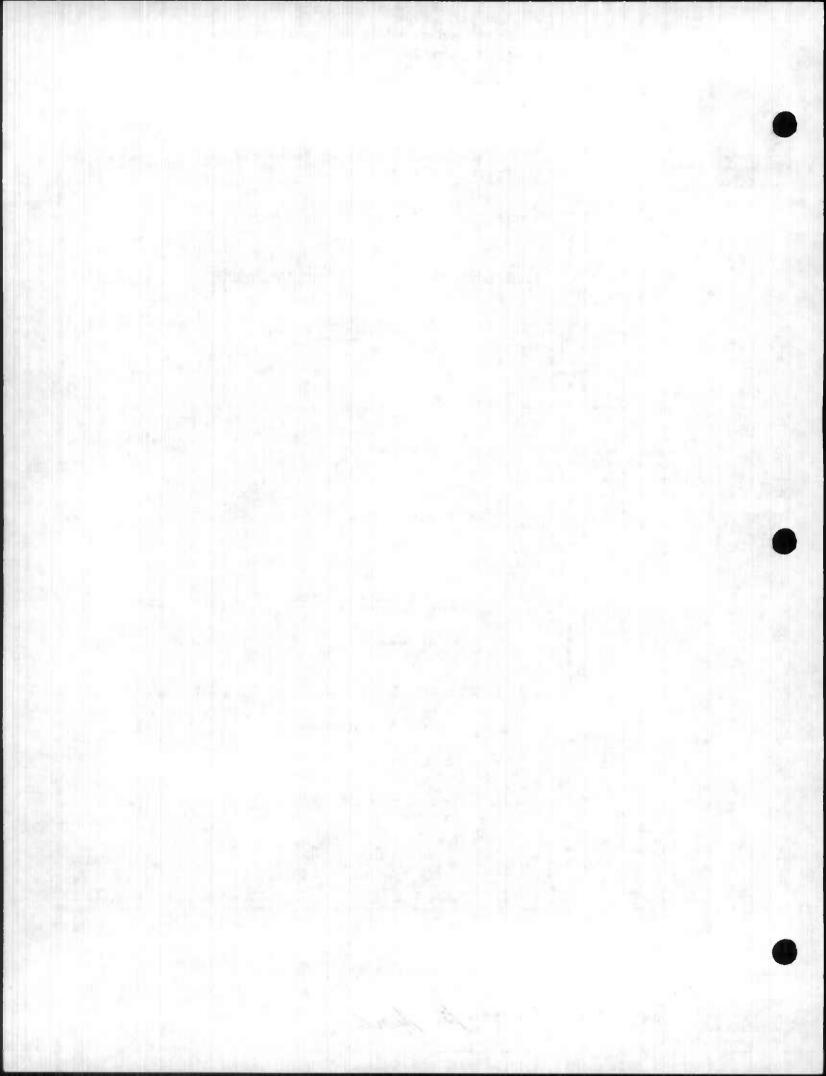
FREDERICK, MD 21701 Kanan Hudhud, mD 801 AVENUE, F TOLLHOUSE

State Registrar 31. Date filed (Month, Day, Year) JAN 3 1 2000

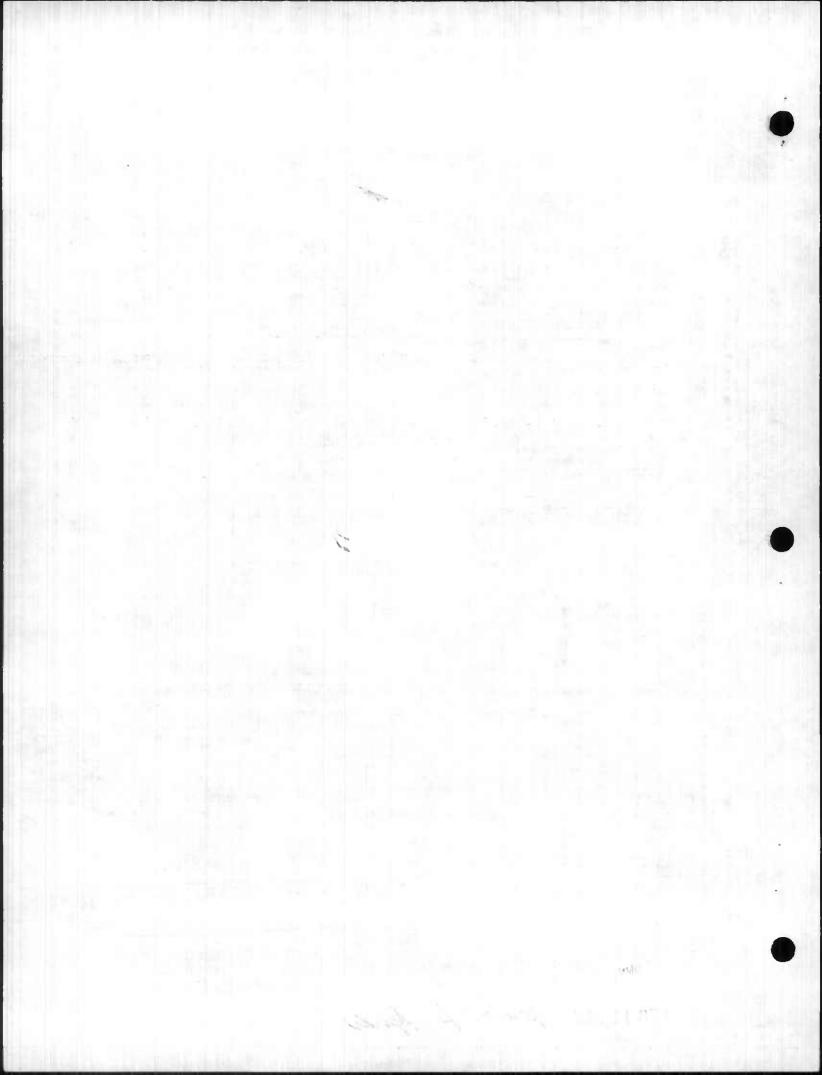
32. Registrar's Signature

after death. Director: After ti

within 24 hours



Randy Bernard Williams 4 Facility Starrey (in institution, give steere and number) 4 Facility Starrey (in institution, give steere and number) 4 Facility Starrey (in institution, give steere and number) 4 Facility Starrey (in institution, give steere and number) 5 Social Social Starrey (in institution, give steere and number) 5 Social Social Starrey (in institution, give steere and number) 5 Social Social Starrey (in institution, give steere and number) 5 Social Social Starrey (in institution) 5 Social Social Starrey (in institution) 7 Social Social Starrey (in institution) 8 Social Social Starrey (in institution) 8 Social Social Starrey (in institution) 9 P. G.		17 5, f				Cert	ificate of	Death		Heg. No.		
4. Facility Name (if not institution, the street and number) CIVISTA HOSPITAL Solution Security Number CIVISTA HOSPITAL SOLUTION	/sician	_		11.					Month	Day		3. Time of Death
CIVISTA HOSPITAL CHARLES S. Social Security Number C. S. Social Security Number C. S. Social Security Number C. CO-43-350 XXM 2D F 7 Age (in yrz. last brinday) Vrs. V		40						4b. City, Town, o		-		0814 AM
Social Security Number Save XRM 3 F 7.40p (first set brindley) Under 1 test Under 1	mmer			- VID				LAPLATA				
Top State Top Control Top State Top Control Top State Top Control Top State		5.						If Under 24 Hr			9. Birth	nplace (State or Foreign
Mode P.G. Indian Head 100 Ze Code 100, Citzen of What Country 206.40 United States 100 Ze Code 206.40 United States 100 Ze Code United States United Sta			220-04-3580	EXW SOL	31	Yrs.			Feb 29	, 1968	Wash	nington DC
11. Marifal Selection					10c. City, To	own or Loca	ation					10d. Inside City Limits
11. Maritel Seture	ctor		MD P.G.		In	dian 1	Head					1□Yes 2□No
11. Married Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or No- 14. Pages - American Indian, Part of Happanic Origin? (Specify Yes or Origin.) (Specify Yes		10		70				0640		-		
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Michael W. Williams 19e. Informat's Name/Relationship (*type, Print) Gary M. Williams (BROTHER) 20e. Method of Disgosition 11 Burisl **Externation 3 Removal from State 4 Bonation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 23. Signature of Funeral Service Licensee 24. Signature of Funeral Service Licensee 25. Place of Disposition (Name of committee) 26. Place of Disposition (Name of committee) 27. Signature of Funeral Service Licensee 28. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest. 27. Same and Address of Facility (Per Funeral Home, Inc. 6633) 28. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest. 28. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest. 29. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest. 29. Part. Enter the disease, or complications that caused the death. No not enter the mode of dying, such es cardiac or respiratory arrest. 29. Part. Enter the disease, or complications that caused the death. No not enter the mode of dying, such es cardiac or respiratory arrest. 29. Part. Enter the disease, or complications that caused the death. 29. Part. Enter the disease, or complications that caused the death. 29. Part. Enter the disease, or complications that caused the death. 29. Part. Enter the disease, or complications that caused the death. 29. Part. Enter the disease, or complications that caused the death. 29. Due to (or as a consequence of): 29. Due to (or as a consequence of): 29. Were autopry performed? 29. Were autopry performed? 29. Part. Enter the disease or contribute to the cause and place of the property of death? 29. Part. Enter the mode of the property of the			3 ☐ Widowed 4 ☐ Divorced	If Yes, Giver Year or Dates:		11	Yes ZNO	Specify:		Specify	r:	White
Michael W. Williams 19e. Informat's Name/Relationship (*type, Print) Gary M. Williams (BROTHER) 20e. Method of Disgosition 11 Burisl **Externation 3 Removal from State 4 Bonation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 23. Signature of Funeral Service Licensee 24. Signature of Funeral Service Licensee 25. Place of Disposition (Name of committee) 26. Place of Disposition (Name of committee) 27. Signature of Funeral Service Licensee 28. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest. 27. Same and Address of Facility (Per Funeral Home, Inc. 6633) 28. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest. 28. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest. 29. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest. 29. Part. Enter the disease, or complications that caused the death. No not enter the mode of dying, such es cardiac or respiratory arrest. 29. Part. Enter the disease, or complications that caused the death. No not enter the mode of dying, such es cardiac or respiratory arrest. 29. Part. Enter the disease, or complications that caused the death. 29. Part. Enter the disease, or complications that caused the death. 29. Part. Enter the disease, or complications that caused the death. 29. Part. Enter the disease, or complications that caused the death. 29. Part. Enter the disease, or complications that caused the death. 29. Due to (or as a consequence of): 29. Due to (or as a consequence of): 29. Were autopry performed? 29. Were autopry performed? 29. Part. Enter the disease or contribute to the cause and place of the property of death? 29. Part. Enter the mode of the property of the					10	(Give ki	nd of work done	during most of w	orking	16b. Kind of B	usiness/1	ndustry
17. Father's Name (First, Micdie, Last) 19. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zp Code)				College (1-4or 5-				•				2
Michael W. Williams 19a. Informant's Mem Prelationship (Type, Print) Gary M. Williams (BROTHER) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zp Code) 4623 Lincoln Ave, Beltsville, Maryland 20705 20c. Mended of Diagopation 1 Bunist Personal Savice Loansee 1 Clinton, Maryland 21. Signature of Funeral Service Loansee 22. Name and Address of Raillingue Fruneral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, Maryland 22. Sart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Causa (Fine) disease or conditions, as consequence of): Sequentially list conditions, as consequence of): Sequentially list conditions, as consequence of): Sequentially list conditions, as consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 25. Was case referred to medical examination of Death Individual Conditions of Conditions		17)		NINGO	w Insta		eme (First, Middle	Resider Suman	itla]	Construct
Carry M. Williams (BROTHER) 4623 Lincoln Ave, Beltsville, Maryland 20705			Michael W. Willi	iams				Susan	Butz	_/19		
20a. Method of Disposition Burist Microard Disposition Dispositi												
Sequentially Sepecify Sepecify Certifying Probably Sepecify Septiment Sep				(BROTHER)				Ave, Be.	1			
21. Signature of Funeral Service Licensee 22. Name and Address of Facility are Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, Marylan 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation for the facility of the cause of the cause on each line. ACUTE ETHANOL, NARCOTIC AND COCAINE INTOXICATION B. Due to (or as a consequence of): 24a. Was an autopsy performed? 24b. Were autopsy performed? 25b. Was case referred to medical examiner? Seaminer? Description of the death of the death of the cause examiner? Description of the cause examiner? Description of the cause examiner? Description of the cause examiner of the cause of the cause examiner of the cause examiner of the cause			1 ☐ Burial 2 Cremation 3 ☐	Removal from State	ceme	tery, creme	ntory or other ple					
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23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enough of heart fishers. List only one cause on each line. ACUTE ETHANOL, NARCOTIC AND COCAINE INTOXICATION a. ACUTE ETHANOL, NARCOTIC AND COCAINE INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): d. Due to (or as a consequence of): 24a. Was an autopsy performed? 24b. Were autopsy performed? 24b. Were autopsy performed? 25c. Was sates referred to medical enough of death of the cause of the complete of the complete of the complete of the cause of the complete of the com			1.4 5 5	-11								
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Due to (or as a consequence of): Due to (or as a consequence of):											1	Onset and Death
Sequentially list conditions, if any, leading to immediate cause, Entire Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or		dis	seese or condition	a	100						1	
Due to (or as a consequence of):					Due to (or as	a consequ	ence of):				1	
Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.		Si	equentielly list conditions,		Due to (or as	a consequ	ence of):					
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25. Was case referred to medical examiner? 1									10	Yes 20 No	3 Pr	obably 4 Unknown
25. Was case referred to medical examiner? 125. Was case referred to medical examiner? 126. Place of Deeth (Check only one) 27. Manner of Deeth 1 Netural investigation 3 Suicide determined 28a. Date of Injury (Month, Dey Year) 28b. Time of A injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No 2 No 1 Yes 2 No 1 Y		-							24a. Wa	s an autopsy	24b. V	Vere autopsy findings
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one)		-							perf	ormed?		completion of cause
examiner? Note Nursing Note Nur									10	Yes 2□No	1	☑Yes 2□ No
No Hospital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								26. Place of De	eeth (Check only	one)		
1 Netural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 5 Determined 6 De			1XXYes 2□ No	1 Linpatier		Outpatient	ADVOA	4 Li Nuising	1			city)
29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(and manner stated.		27.	1 □Netural 5 □ Pending	(Month Clavi	Voorl		A 28c. Inju				red	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.	0		3 Suicide 6 Could not be		7001	/ .		•••	20f Longtion	Change and Mirms	per or Ru	ral Route Number,
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.	2		4 Homicide				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Place	LaPlata	OMO	na Farm
	10			ysician: To the best of	my knowled	ge, death o	occurred at the ti	me, date and place	e, and due to the	cause(s) and m	anner as	stated.
	Certification: To	29	(Uneck only 2) Allian(es) Evan.	and manner stat	led.	2110201 11110			Julies at the time			
OCME FEBRUARY 6, 2000	edical Certification: To	29	one)				29C. LICON					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	edical Certification: 10	29		101,				ME			17 11	
Dennis Chute mo 111 Penn Street, Baltimore, Maryland 21201	Certification: To	29	b). Signature and title of certifier	1 Chute,	40	1) (Time P		ME		I DDNOAL	(1 0	2000



State of Maryland /	Department of	of Health and	Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month JANUARY **Physician** William Weems, Sr. 21, 2000 10:17PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** St. Mary's St. Mary's Hospital Leonardtown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) | July 12, 1943 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funerai** 56 216-40-7994 Yrs. Maryland Director Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23a or 28a-f show treumstic event, the Modical Examiner must be notified at 1 Yes 2 No Directo Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20657 378 Longhorn Circle 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. within 72 hours efter 1 Never Merried 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 end 2 should be filed wi Department of Health end Mental Hygien, Important: If Item 27 is marked other tha any injury or other treumeits Construction 12 Laborer 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Wilson Weems Maurice 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code, 1955 Scientist Cliffs Road Port Republic, MD 20676 Ruth Weems/Wife 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from Stete 1/28/00 St. John UMC Cemetery Lusby, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licanses 22. Name end Address of Fecility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel Probable Myseandial Infanction
Due to (or as e consequence of): diseese or condition resulting in death) Examiner Examiner buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest and Due to (or es e consequenca of): Box 68760, physician Physician/Medical the Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown It y per terson Records, Completed by 24b. Were autopsy findings eveilable prior to 24a. Was an autopsy performed? completion of cause of deeth? is certificate hes l director, page 2 s 1 Yes 1 ☐ Yes 2 ☐ No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yes 2 No 30 DOA Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient to 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Division 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) and manner es stated.

Madicei Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. Medical 29a Certifier 29b. Stanature and title of certif er 29c. License number 29d. Date signed (Month, Day, Year) 018582 1-22-00 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) DR. WILLIAM D. BOYD II LEONARDTOWN, MD. 20650 31. Date filed (Month, Day, Yeer) 32. Registrer's Signature State

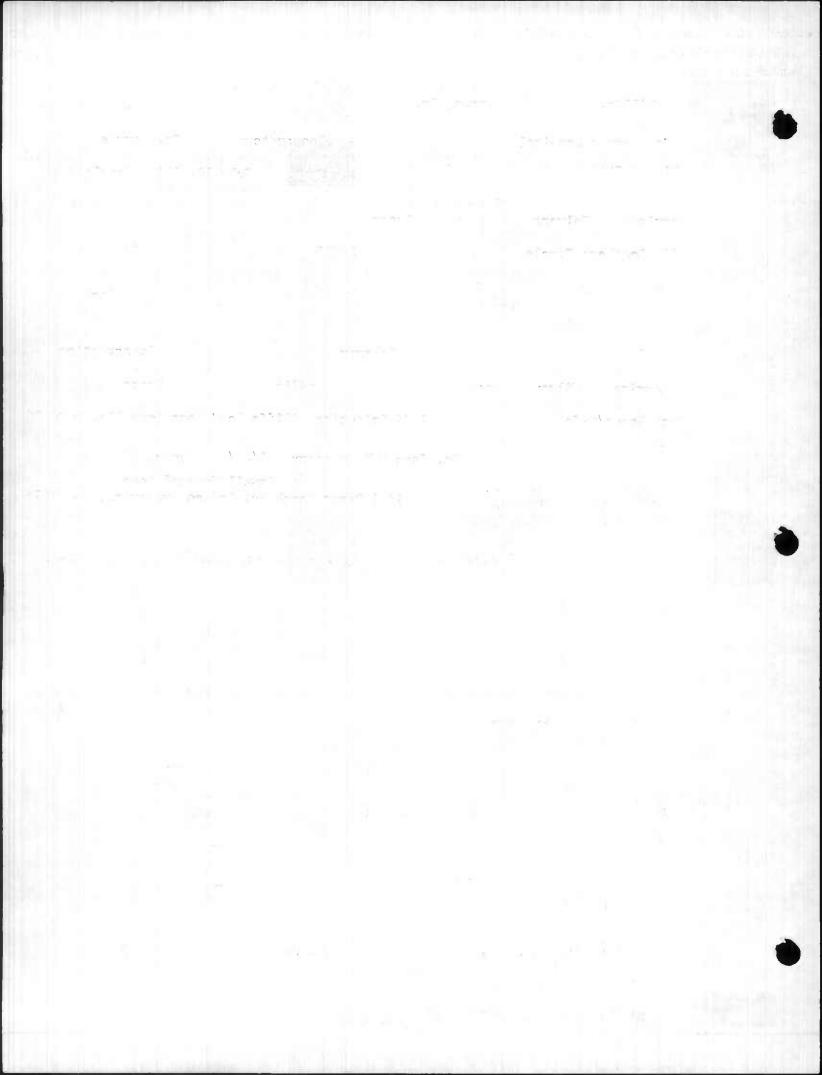
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Registrar

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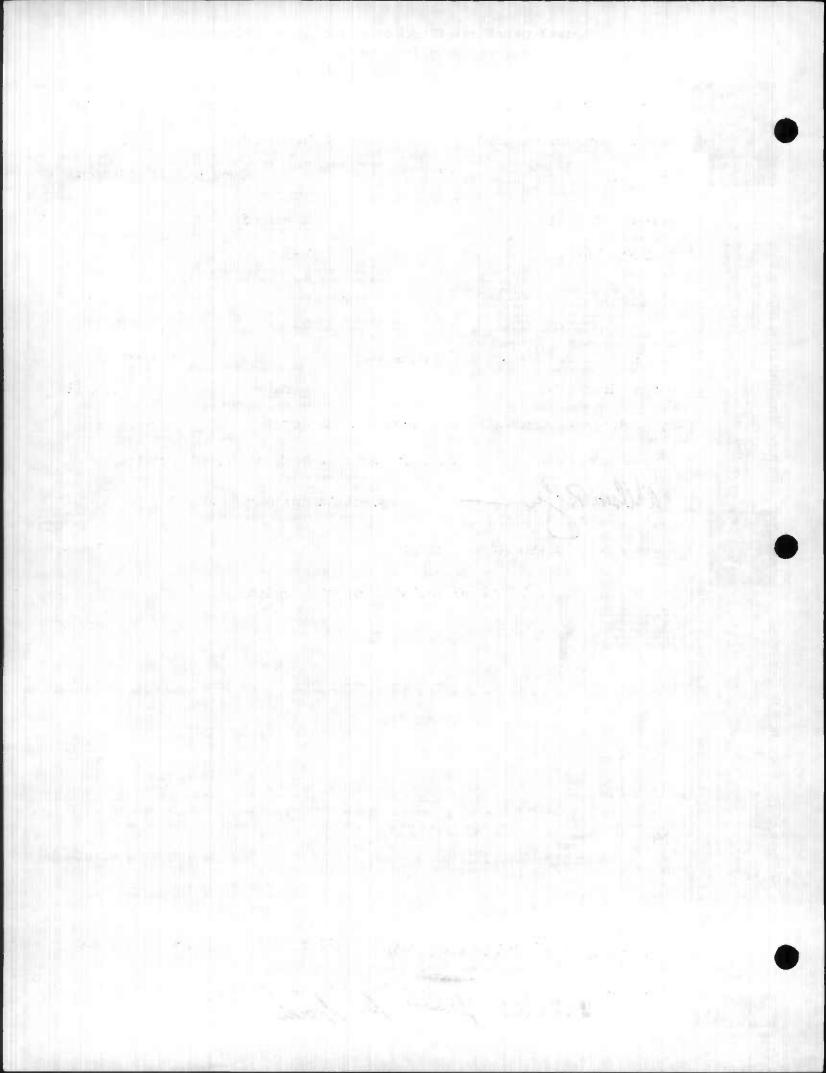


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				lest birthdey		1 Year	If Under 2			9. Birthplace (Stete or Foreign
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Direc	10e. Street and Number		•		10f. Zip		20,600				
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	21. Signature of Fuperal Service Lice	he-	_				·		., Owing	s, MD 2	0736
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ledical	29a. Certifier 1 Certifying P	minar: On the basi	s of examinal		nvestigation		oinlon, deatl		, date and placa,		cause(s)
	To Be Completed by Physician/Medical Examiner	GAY OVERMAN 4e Facility Name (If not institution, giral Calvert Memorial 5. Social Security Number 264 41 3615 Usual Residence of Decedent 10a. State 10b. County Maryland Calvert 10e. Street and Number 5740 Highland La 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest giral) Elementary/Secondary (0-12) 5. 17. Father's Name (First, Middla, Last George Henry Dirac) 19a. Informant's Name/Relationship Gay A. Rodgers / 20a. Method of Disposition 1 We Burlal 2 Cremation 3 In 4 Donation 5 Other (Special Second Cause) 21. Signature of Funeral Service Lice 22a. Part1. Enter the disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Part II. Other eignificant conditions ANEMIA 25. Wes case referred to medical examiner? 1 Yes 2 No	GAY OVERMAN YOUNG 4e Facility Name (If not institution, give street and number Calvert Memorial Hospital 5. Social Security Number 8. Sex 264 41 3615 Usual Residence of Decedent 10e. State 10b. County Maryland Calvert 10e. Street and Number 5740 Highland Lane 11. Manital Status 1 12. Was Deceded Armed Force 1 13. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4-5) 17. Father's Name (First, Middla, Last) George Henry Duke 19a. Informant's Name/Relationship (Type, Print) Gay A. Rodgers / daughter 20a. Method of Disposition 1	GAY OVERMAN YOUNG 4e Facility Name (If not institution, give street end number) Calvert Memorial Hospital 5. Social Security Number 264 41 3615 Usual Residence of Decedent 10e. State 10b. County 10c. State 10b. County 10c. Street and Number 5740 Highland Lane 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. 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Signature of Funeral Service Leonage 22a. Part II. Enter the disease or combilications that causad the death. 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Social Security Number 5. Social Security Number 5. Social Security Number 108. Street and Number 5. Social Security Number 108. Street and Number 5. Social Security Number 100. Security Number 100. Maining Address (Street and Number of Nu	GAY OVERMAN YOUNG Facility Name (frinct histatius, give steets and number) Calvert Memorial Hospital S. Social Security Number 264 41 3615 100 County Maryland Calvert 100 County	GAY OVERMAN YOUNG GAY PACIFICATION OF THE CALLEY CONTROL OF STORY

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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death · 14AM Year EARL. E. ARTHUR JR FEBUARY 12, 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BACTIMILE SAMARATAN HOSPITAL NIN H Under 24 Hrs. 8. Dale of Birth Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Ye Months Da 6. Sex 5. Social Security Number 9. Birthplace (State or Foreign Country) Days 214-36-5078 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Tes 2 No BALTIMERE MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 V.S.A. PARKWAY EASTERN 6510 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, Whita, etc. 1 Never Married 2 Married 1 Yes 20 No Specify: Specify: WhiTe 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ConsTRUCTION, COMP. 12th ESTIMATOR 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EARLE. ARTHUR Shipley ELSIE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 1819 DR. BOLTO. MD EARL. E. ARTHUR III SON Darrich 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2/16/2000 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BA170 MD Cenetery PARKWOOD 4 ☐ Donation 5 ☐ Other (Specify) Miller Fineral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HARTLEY BOLTO. HARFORD . RD. 7527 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 3 NO 1 ☐ Yes 2 D No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ENOutpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Greatural 5 Pending investigation 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

Examiner The lew requires that the deeth certificate be executed Box 68760. P.O. Records, Division of Vital or Attanding Physicien:

Physician

/Medical

Examiner

Director

Funeral

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Physician/Medical

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Medical Certification: To

29a. Certifier

(Check only one)

29b. Signature and title of certifier

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Funeral

Director

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Pages 1 and 2 should be fill ment of Health and Mental H anti: If them 27 is marked oth lury or other traumatic even

Physician /Medical

filed within 72 hours after

Baltimore, Maryland 21215-0020

24 hours Funeral D completely within 2 5

DHMH 16 Rev 6/95

certificate has

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State Registrar

31. Date filed (Month, Day, Year) FEB 16 2000

30. Name and address of person who compl ted cause of death (Item 23a) (Type, Print) 61055 M. 32. Registrar's Signature

GEOR

CMD

9660 BelaiL LD, BOLTD. ND

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D18758

29d. Date signed (Month, Day, Year)

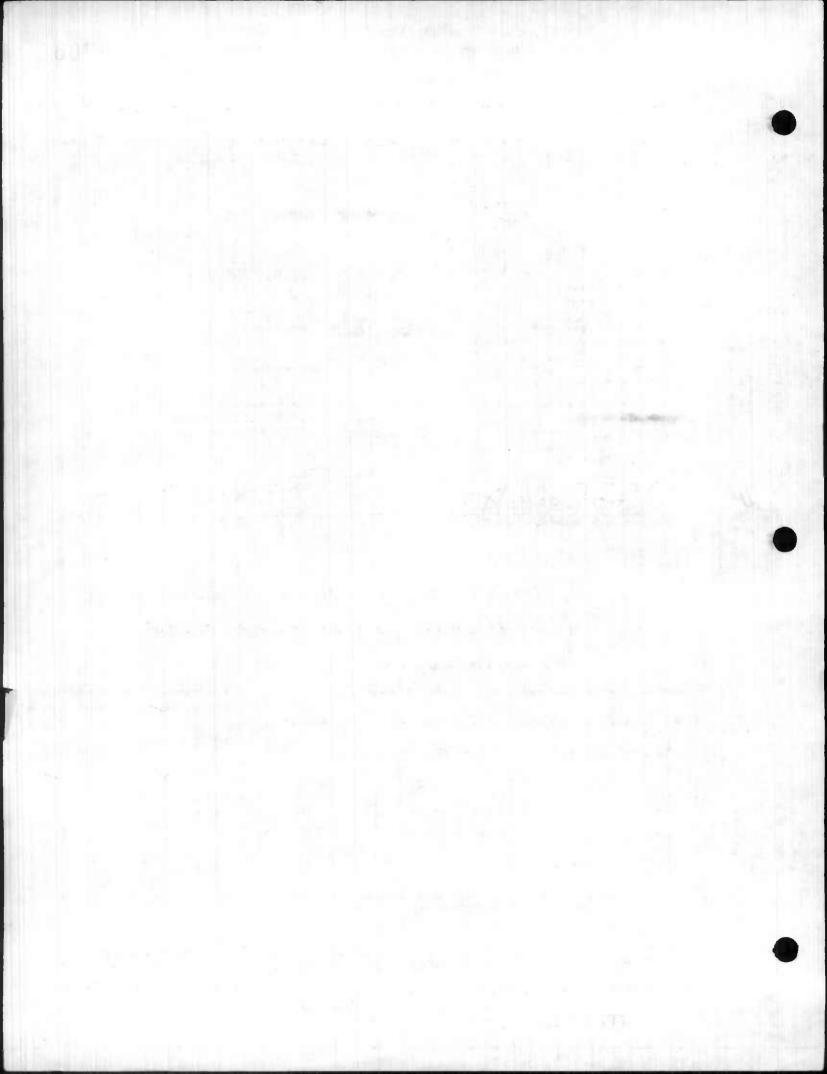
Feb-14-2000

State of Maryland / Department of Health and Mental Hygien

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 10:16 AM LUCILLE AGATHA BOYCE 2 00 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner COMMUNITY HOSPITAL PRINCE GEORGE DOCTORS LANHAM ar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Davs 110-44-3609 1□ M 100 F 83 July 11, 1916 Director Guyana Usual Residence of Decedent the Marvand 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits Prince Georges 1 Yas YNO Director Mitchellville 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b na 23a or must be 1222 Kinos Tree Drive 20721 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22000 off Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, Whita, atc. Mad within 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 20(No Specify: Black Specify: ž 3 St Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant; if item 27 is marked oth lury or other traumatic even Be Wallace Jones Mary Ryner 19e. Informent's Neme/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) San Roderick Boyce 119-42 232 Street Cambria Heights NY 11411 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata permit. Page Department of Apportant: If age Injury or ages. Maple Grove Cemetery February 14, 2000 Kew Gardens, NY 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 23a. Part1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on aach line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final · HYPOTENSION disease or condition resulting in death) e a a mine Dua to (or as a consequence of): Examiner DEGREE A-V BLOCK DIHIRD ician and burial-transit or Attanding Physician: The law requires that the death certificate be assecuted Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 c. HYPERTENSIVE CORONARY VASCULAR DISEASE
Due to (or as a consequence of): Physician/Medical the US0 88 HYPERTENSION Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tohacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown UNCONTROLLED DIABETES MELLITUS by Records, 24b. Ware autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed ALZHEIMERS DISEASE 1 Yes 2 No 1 Yas 2 IN Division of Vital 25. Was casa referred to medical 8 26. Place of Deeth (Check only one) axaminer? 1 ☑ Yas 2 ☐ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To Sie Sie 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ENaturat 5 Pending within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mennar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the ? 29c. License number 29b. Signatury and titla of certifier 29d. Data signed (Month, Day, Year) 00048365 2-7-00 30. Nama and piddress of person who complete oled cause of death (Item 238) (Type, Print) 12172 CENTRAL AV. STE. 100 MITCHELLEVILLE EUPHEMIA R. BRUMSKINE -OTANG, MO MD 20721 31. Date filed (Month, Day, Year) State socks Registrar

DHMH 16 Rev 6/95

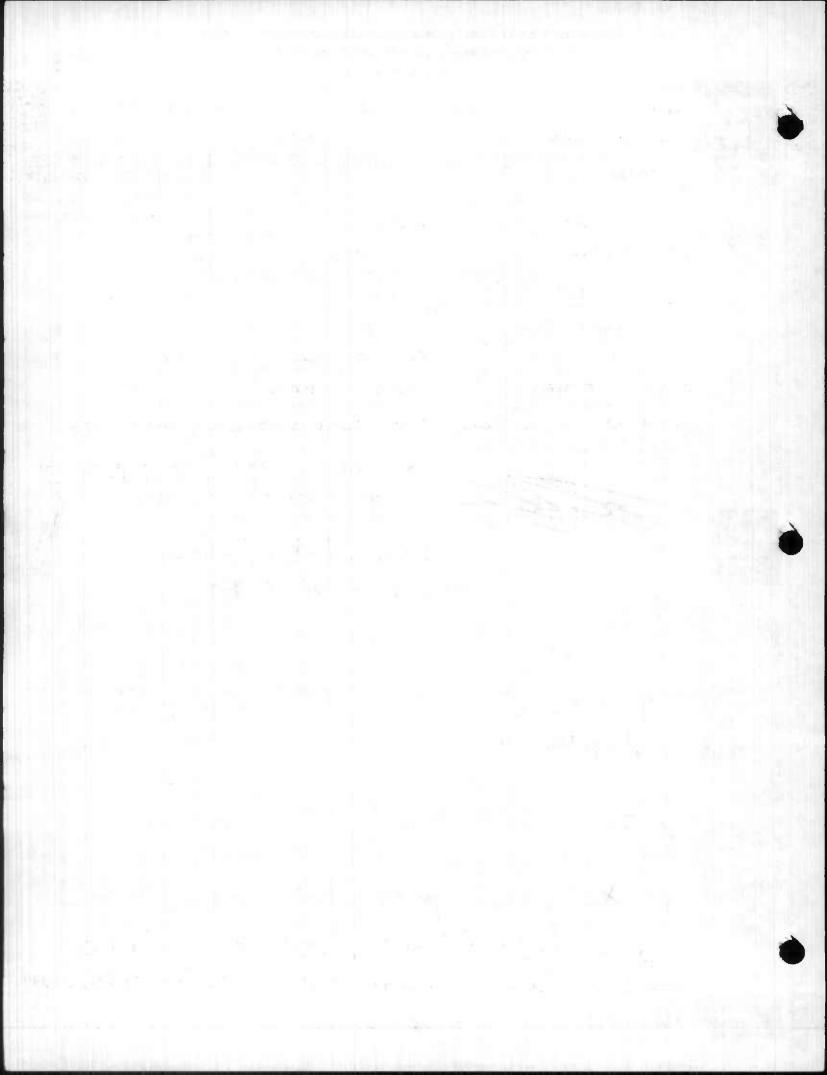
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State of Maryland / Department of Health and Mental Hygiene

				Otato of N	iai yiai ic		tificate of	Death		g. No.	01	+789		
П	Physici	an	1. Decedent's Name (First, Middle	, Last)					2. Date of Death Month	Day	Year	3. Time of D	th	
Ų,	/Medi		ARTHUR		VID		BODKIN		FEBRUAR	Y 13, 2	2000	7:00	M	
	Examir	ner	4e. Facitity Neme (If not institution 2820 LAKE AVEN		r)		×	4b. City, Town, or Lo BALTIMOR		4c. County	of Death	A		
	Funerai Director		5. Social Security Number 234–32–1231	6. Sex 7. A	Age (In yrs. Ia 7	st birthday) 19 Yrs.	ff Under 1 Year Months Days		8. Date of Birth (Month, Dey, NOV. 26			ace (State or I		
	yland		Usual Residence of Decedent 10e. State 10b. County		10c. City,	Town or Loc	cation	<u> </u>			10	Od. Inside City		
	e Ma	Director	MARYLAND N/A	A	-	BALT	IMORE					1 ☐ Yes 2	2 № No	
	it 15 00 20 00 00 00 00 00 00 00 00 00 00 00	Dire	10e. Street and Number				10f. Zip Code		10	g. Citizen of W	/hat Coun	try?		
	23a		2820 LAKE AVENU			Ties	21213			.S.A.				
020	hours after death with the Maryland tural', or Items 23s or 28s-f show all Exercinet trast be notified at	by Funeral	11. Marital Status 1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Was 2 □ H Yes, Give Year or Dates:		7 No 194	No 1941- If Yes, specify Cuban, Mexican, Puerting 1 Yes 2 No Specify:			ecify Yes or No- Rican, etc.)		k, White,	nerican fndian, nite, etc. WHITE		
21215-0020	hin 72 in "nat	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed)	lucation		18a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)		orking 16b. Kind of E		Business/Industry			
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lan	should be filed and Mental Hygi marked other imatic event, I	o Be		ASENT		BODE	CIN	FLORIA	e (First, Middle, IV					
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altir	permit. Peg Department Important: If any injury o		21. Signature of Funeral Service L		PAR	KWOOD 22	CEMETER: Name and Addre	y 20 Pess of Facility SIN	OOO L	BALTIM	ORE,	MARYLA	ND -	
Ö	Depariment Important Important Income		1					AVENUE, S.						
			23a. Part Limer the therease, or shock premart fallure. List	complications that cause thy one cause on each	ed the death.							Approximate Interval Between	een .	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Ac	te	4/	oco 101	lial w	faction	N		Onset and De	eth	
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á	ificate be executed g physician end as the burlel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		Due to (or	as a consequ	uence of):							
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o.	0 0 2	Physician/	Part II. Other significant condition	ns contributing to death	but not result	ting In the un	derlying cause gi	ven In Part I.	23b. Dfd tol	s 20 No	tribute to		death?	
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Records,	requir been s should	Completed	Hypert	MSISN					24a. Was ar perform		ava	re autopsy fin- uitable prior to appletion of cau death?	_	
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Vital	dcian: The I certificate he rector, pege	Be	25. Was case referred to medical examiner?					28. Place of Deat	h (Check pnly one)				
of	5 00 5	7	1 Yes 2 No	Hospital:		R/Outpatient	3LI DOA	her: 4 Nursing Ho	1	nca 6 □Othe		')		
ono	After After funer	tion	27. Mariner of Death 1 Natural 5 Pending investig		ay Year)	28b. Time of Injury	28c. Inju Wo	ryat rk?]Yes 2 □ No	28d. Describe ho	w injury occurr	ed			
Division	I or Attending Physician: after death. Director: After this certific d in by the funeral director,	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of tr	njury - At hom etc. (Specify)	ne, farm, stre	et, factory, offica	7103 2 2 110	28f. Location (Str City or Town		er or Rura	Route Numbe	97,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical C	29a. Certifier (Check only one)	Physician: To the best miner: On the basis and menner s	of examination	ledge, death on and/or inv	occurred at the ti estigation, in my o	me, date and place, opinion, death occurr	and due to the ca red at the time, da	use(s) and ma ite and place, a	nner as st and due to	ated. the cause(s)		
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	W		30. Name and address of person w	the completed cause of	death (ftem 2	Zda) (Type, F	2801	Hubso	IN ST	RAI	TAL	1024	224	
	Sta	te	31. Date filed (Month, Day, Year)	The second secon	trar's Signatu	ire	0,001	110000		4130	101	NOW /	70.1	
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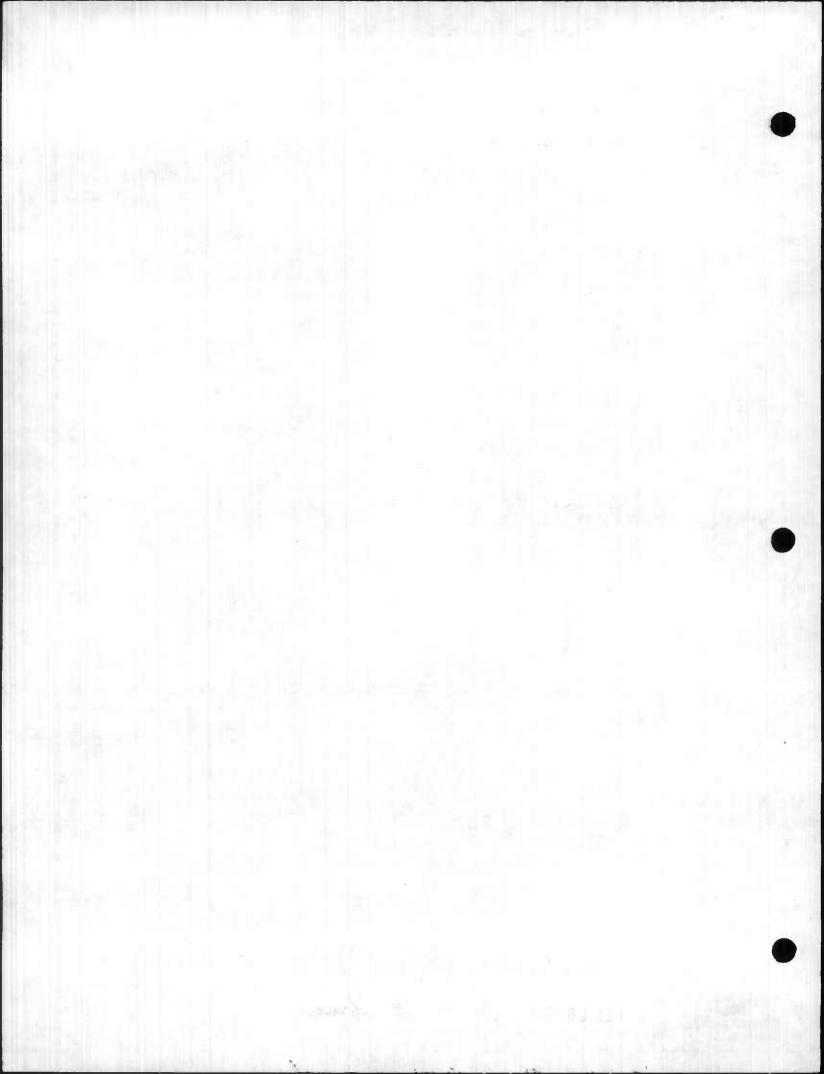


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** February 13 20W

4b. City, Town, or Location of Death 74c. County of Death 10:10 am Herman L. Billmann /Medical 4a Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. iest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1₩ 2□ F Yrs. **Director** 213-26-6170 70 25,1929 | Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore 288-1 Catonsville 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or Funeral 613 Crosby Road 21228 United States
14. Race - American Indian, Beme 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If Hem 27 Is marked other than "natural", or fa ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be John Billmann Lina Leutbecher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) nt of Health a if them 27 is or other tra Vivian Billmann (Wife) 613 Crosby Road Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 12D Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or otics. 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 2/18/00 Pikesville, MD 21 Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, 21227 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each the not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Multiple disease or condition resulting in death) Myelomo Lyear Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): Box 68760. physician Due to (or as a consequence of): USB 88 Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yea 2 No 3 Probably 45 Unknown Anemia Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? certificate has page 2 1 ☐ Yes WNo 1 Yes 2 1 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specity) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. completely (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAUTIMORE MARYLAND 21218 - HUSPITAL LAURIE PROTHMAN UNION MEMORIAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2000 FEB16 Registrar



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month 3. Time of Death BERGSTOL Year **Physician** 2.50 Am BORGHILD 4a Fecility Nama (If not institution, give street and number) FEBRUARY /Medical 4c. County of Death 4b, City, Town, or Location of Death Examiner ARUNDEL GLEN BURNIE ANNE ARUNDEL HOSPITAL If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□ M 2 F Days -28-053 Yrs. Director Usual Rasidence of Decedent filed within 72 hours after death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic avant, the Medical Exercises must be noutled at once. 1 Yes 2 No Director EN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 No If Yas, Give 1□ Yes 2D No Be Completed by WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) TEK 10 Baitimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) BORGHILD TERESE GUNVILDE JOHANSEN 0 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) MAN DR. GLEN BUXNIE, HD 10NA-SSEN 20b. Place of Disposition (Name of cemetery, crematory or other p FEB 15 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Othar (Specify) 5 □ Othar (Specify) BALTIMORE CO. HD 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facilit 70 23a. Part1. Entar the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical UROGERSIT Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, Medical Certification: To Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? cartificate has 2 2 No 1 Yes 1 Yas or Attending Physician: 25. Wes case referred to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this 28b. Time of Injury tha funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Panding invastigation 1 Yes 2 No within 24 hours aftar death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. complataly (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Dete filed (Month, Per, Hear) 6 2000 32. Register: Signature

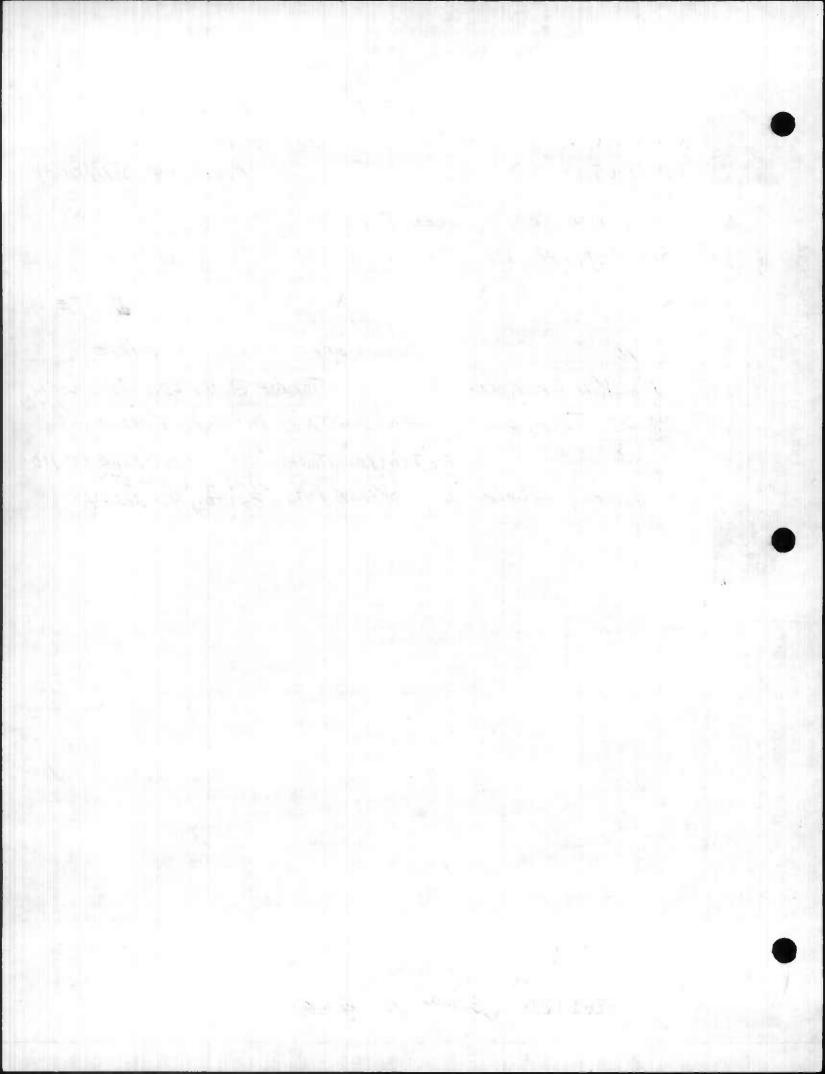
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRIVE CHEN BURNIE

COOP C 21

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Registrar



Physician /Medical Examiner

Department of Important: If eny Injury or page.

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23s or 28s-f ehored call Examples must be notified at

Pages 1 and 2 should be filed within 72 hours effer ent of Health and Mental Hyglene. Interest of the marked other than "natural", or he iny or other traumatic event, the Medical Emerica.

Baltimore, Maryland 21215-0020

Box 68760.

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page 2

Physician/Medical Examiner sician and buriel-transit physician s the burie á Completed 8 Certification: To this

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State Registrar

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2 Accident

3 Suicide

29e. Certifie

4 ☐ Homicide

(Check only one)

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6 Could not be

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

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1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

D03655

PKW Baltimore Mo

21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FUCHS MD

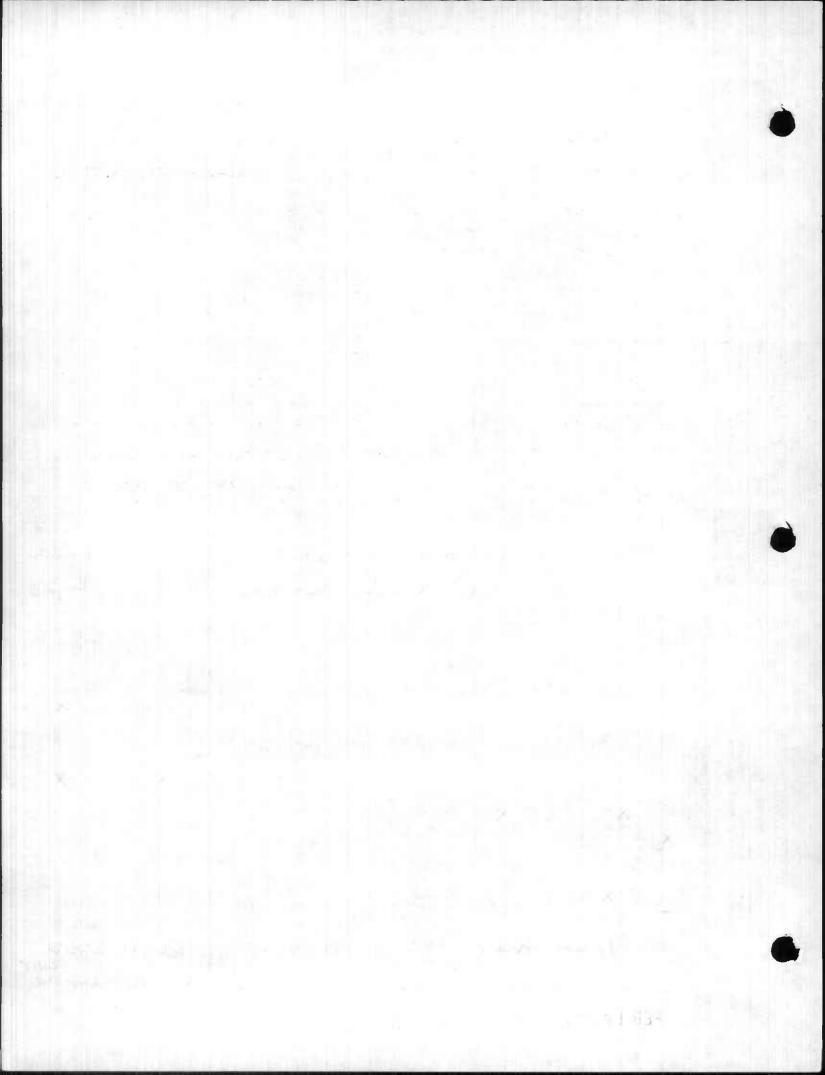
UNIVERSITTY

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Sparkers



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #8 PER F.H. G780 2-15-2000 WR . Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month BERTRAND ELLEN February 10, 2000 8. Dete of Birth-4-1920 9. Birth-4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth Geriatric & Rehab Center Middle River 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. lest birthday) 6. Sex 1□M 2 F Deys Months Hours 217-05-5944 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 M No Maryland Rosedale Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5715 Cynthia Terrace 21206 United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 St Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White

Funeral Director death with the Maryland r 28a-f show item 27 is marked other than "natural", or items 23s or other traumstic event, the Medical Example result be a permit. Pages 1 and 2 should be filed within 72 hours after or Depentment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter Baltimore, Maryland 21215-0020 6 any Injury

Physician

/Medical

Examiner

10a. Slete

Director

Funeral

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Physician /Medical Examiner

> Examiner Physician/Medicai þ Completed Be 2

> > Certification:

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attending physician end for use as the bunal-transit death certificate be executed signed by t has after death.

Director: After this certifications funeral To the Hospital within 24 hours a To the Funeral C Hospital

Division of Vital Records, P.O. Box 68760,

0 State Registrar

FEB 1 6 2000 **DHMH 16 Rav 6/95**

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

MA

Market Plane Ballinere MD 21222

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Merchandiser Hallmark Retail Not Known 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surneme) Edna Sahm John Weidner 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21206 Mr. Edward Bertrand/Husband 5715 Cynthia Terrace Rosedale, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State Moreland Mem. Gdns. 2/14/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of unerel Service Licensee 22. Name end Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter in disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or had failure. List only one cause on each line. ALZHEIMERS DISEASE Immediate Cause (Finel diseese or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es a consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)



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State of Maryland / Department of Health and Mental Hygiene 0 0 4 7 9 4

	Decedent's Name (First, Middle, Las	st)		Certifica	10 01	Death	2. Date of De	Reg. No.		3. Time of Dea		
ian	1		R	LADY			Month	Day	Year	31111		
ical	4a Facility Name (If not institution, give		0,	-407	T	4h City Town	or Location of Deat			0000		
iner		1 .				BAUTIM			year 2000 0300 by of Death N/A 9. Birthplace (Stata or For Country) Maryland 10d. insida City L 1 Yes 2 II What Country? S. aca - American Indian, ack, White, etc. ify: White Business/Industry A Home In, State, Zip Code) Yland 21227 - City or Town, State In, Maryland Home P.A. Md. 21225 Approximate Interval Between Onset and Death 3 G. Hould Countribute to the cause of death? 10 document of death? 10 document of death? 10 yes 2 Note there (Specify) urred			
		sp.tul	Marine Read hiles	H Hod	er 1 Year	If Under 24 h						
	5. Social Security Number 6. S	ex /. Age	(In yrs. lest birt	rs. Month			Ain. (Month, De	ay, Year)				
-	214 72 0785 Usual Residence of Decedent	1.	43		1		Dec. 1	1, 1956	Mar	yland		
-	10a. State 10b. County		10c. City, Town	or Location					100	d. Insida City Li		
6	Maryland N/A		Balti	moro						1⊠ Yes 2□		
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E .	466 S. Bentalou											
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	1 Never Married 2 Merried	1 ☐ Yes 2 🔯 N If Yes, Give	lo	1 ☐ Yes	2 1X No	Specify:		Specify	· Talla	ito		
	3 ☐ Widowed 4 X Divorced	Year or Dates:							WILLCE			
5	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Decedent's Us (Give kind of v	vork done	ation during most of	working	16b. Kind of Bu	usiness/Indu	stry		
Completed	Elemantary/Secondary (0-12)	College (1-4or 5	+)	 Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) 								
	11th			Homemak	cer			me (First, Middla, Maidan Sumame)				
Ď	17. Father's Name (First, Middle, Last)								10)			
0	J	John Slaughter Iva Wa										
	19a. Intormant's Name/Relationship (1	Type, Print)	19b.	Mailing Addre	ss (Street	and Number of	Rural Route Numb	er, City or Town,	State, Zip C	Code)		
	Cindy Slaughter	/ Daughter		107 Smi			Baltimo	re, Mary	ryland 21227			
	20a. Method of Disposition		20b. Place of cemetar	Disposition (N	ame of	ce)	Date	20c. Location -	City or Tow	n, State		
	1 ☐ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specific			p Serv			2/16/00	Towson	, Mary	vland		
-	21. Signature of Funeral Service Litter		1122200	-		-	1					
	Gonce Funeral Home P.A.											
	4001 Ritchie Highway Baltimore, Md. 21225											
	23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	Immediate Cause (Final disease or condition a Brain Douth resulting in death)											
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Curcai	Cause (Disease or Injury that initiated events resulting In death) Last		Due to (or es e c	onsequence of):					1		
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and		d	a wall	TW IN	10.1017	7				,		
Completed by Physician/M	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying	cause giv	ven in Part I.	23b. Did	tobacco una con	ntributa to t	the cause of de		
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	Intereneus Day	6 USE					_			7517		
								s an autopsy ormed?	24b. War	e autopsy tindir		
Sec.					_	01111001	completion of cause					
Ē							10	Yas 2 No	10	Vas 217 No		
5	25. Was case reterred to medical					OC Diseaset				100 2/2/10		
0	examiner?	Hospital:			Oth	201	Death (Check only		(C//-)			
2	27. Manner of Death	1 Impatie				4 Nursing Home 5 Hesidence 6 0						
Certification:	1 ☑ Natural 5 ☐ Pending	28a. Dete of Injur (Month, Day	Year) Ir	njury M	28c. Inju	rk? Yes 2 □ No	28d. Dascribe how injury occurr			9G		
20	2 Accident Investigation 3 Suicide 6 Could not be		a. Athens fo			700 2 0110	29f Location	(Street and Numb	or or Rural	Boute Number		
	4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
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	(Check only 2 Medical Exam	ysician: To the best on niner: On the basis of										
Ca	one)	end menner ste	ted.									
-				2				29d. Date signe	a (Month, D	ay, Year)		
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Medic	10,		<u> </u>	Type, Print)	RES	- 000		2/12/0	00			
Σ	30. Name and address of person who		aath (Item 23a) (Type, Print)	RES	-000	nital	2/12/0	00			

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Ruby Ebruary 12, 2000 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ottmore (ty) Juder 24 Hrs. 8. Date of Birth ours Min. (Month, Day, Year) 5. Social Security Number 6. Sex If Under 24 Hrs. If Under 1 Yea 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1 ☐ M 2 🛛 F 94 218-01-8894 Maryland Jan.6,1906 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Baltimore 1 N Yes 2 No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 3330 Wilkens ave. 21223 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2€ No Specify: Specify: White ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3rd Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (unavailable) Simont Archibald Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Barnes/daughter 300 Edward Ave. Linthicum Heights Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 2/15/00 Balto., Md. 22. Name and Address of Facility Gonce Funeral Home P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hwy. Balto. Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LEFT MIDDLE CEREBRAL - INFARITION 3 MONTHY. Due to (or as a consequence of): ATHERES CLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown ALZHEIMERS DEMENT A 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CONGECTIVE HEART FAILURE. 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work?

Examiner physician and s the burial-transit

Box 68760,

P.0.

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

flams 23s or 28s-f show

"natural", or

Hygiene.

permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien (mportant) if hem 27 is marked other the any Injury or other transments.

Physician

/Medical

Ruby BA Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

Examiner Physician/Medical þ Completed Be Certification: To

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of confider

3 Suicide

this or Attending Patter death.

Director: After d in by the funer After

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

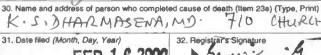
Registrar

edical

31. Date filed (Month, Day, Year) FEB 1 6 2000

5 Pending investigation

6 Could not be determined



Laurene, Ms.

CHURCH ST. BALTIMORE, MD 21225

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number D17753

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

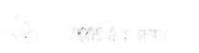
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2-12-2000

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Yee Month **Physician** LUTTEXI DORIS Mac 02 11,20pm 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Healthcare Of Forest Hill ForestHill Harford If Under 1 Year 5. Social Sacurity Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1□M 20 F Months Days Hours 21620359 Yrs Director 2-16-1927 Baltimore Usual Residence of Decedent with the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits ahon 7 is marked other than "natural", or thema 23a or 28a-f shor traumatic avent, the Medical Examinar must be notified at 1 ☐ Yas 2 No Director Md. Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 646 Harborside Drive Apt. 21085 USA Funeral 12. Was Decedent Evar in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 72 hours after 0 1 Navar Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: White by Specify: 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be filed Department of Heelth and Mental Hygid Important: If item 27 is marked other I any injury or other traumatic avent, III 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Joseph Eich Edna Emminizer 19a. fnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank J. Curreri- Son 646 Harborside Drive Apt. F, Joppa, Md 21085 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery2/15/2000 Baltimore, Md. 21. Signature of Funeral Service Licensee

Lary R. **Di Giovanni

Gary R. **Di Giovanni

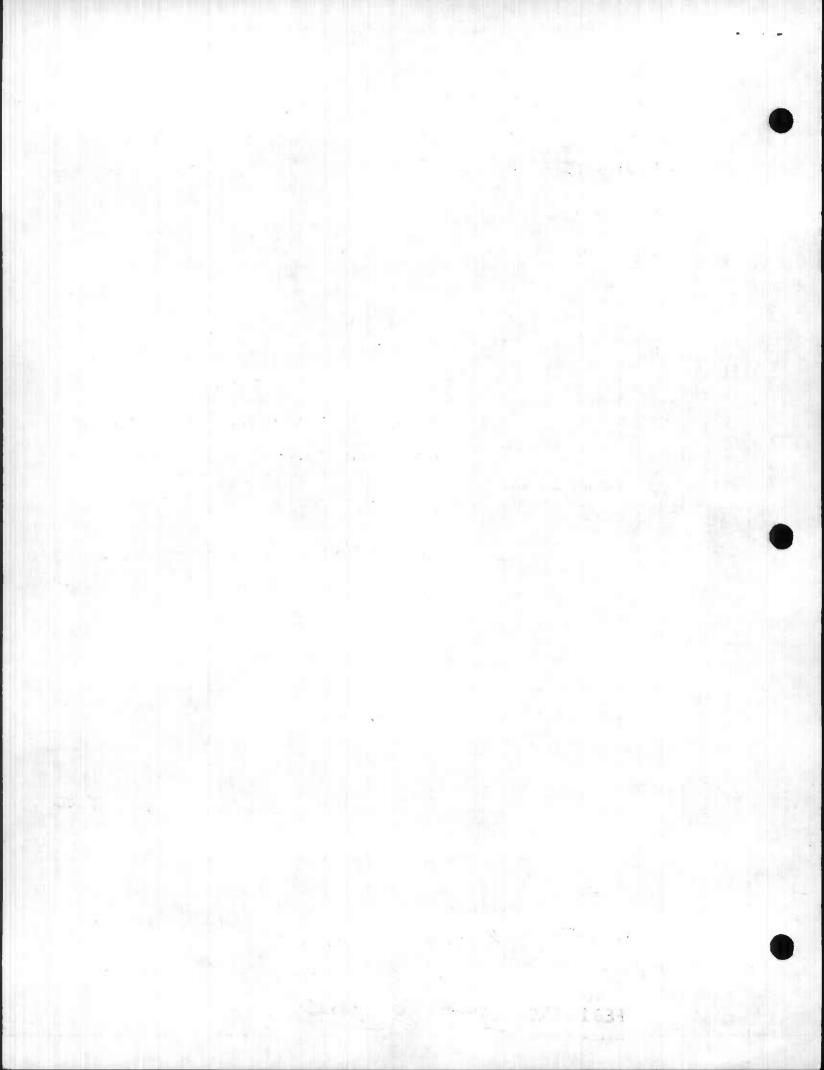
23a. Pert 1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. 22. Name and Address of Fecility Leonard J. Ruck Funeral Home Md. 21214 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disaasa or condition resulting in death) Examiner Examine physician and the bunat-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Sees 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was en autopsy 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was casa referred to medical axaminer? Be 26. Place of Deeth (Check only one) 6 Hother (Specify) Whateut Other: 4 Nursing Home 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P 5 Residence 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. fnjury at Work? 28d. Describe how injury occurred To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera edical Certification: After t Division 1 DNaturel 5 Pending Investigation 1 Yes 2 No 2 Accident outet 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number City or Town, Stete) Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Decrifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29c. License number D 16 3 8 9 29d. Date signed (Month, Dey, Year) 29b. Signature and title of Cortilie MARAO, M.D. 1716 HARFORD RD FAUSTON 210 21047 30. Name and address diperson who PERPECTO C. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

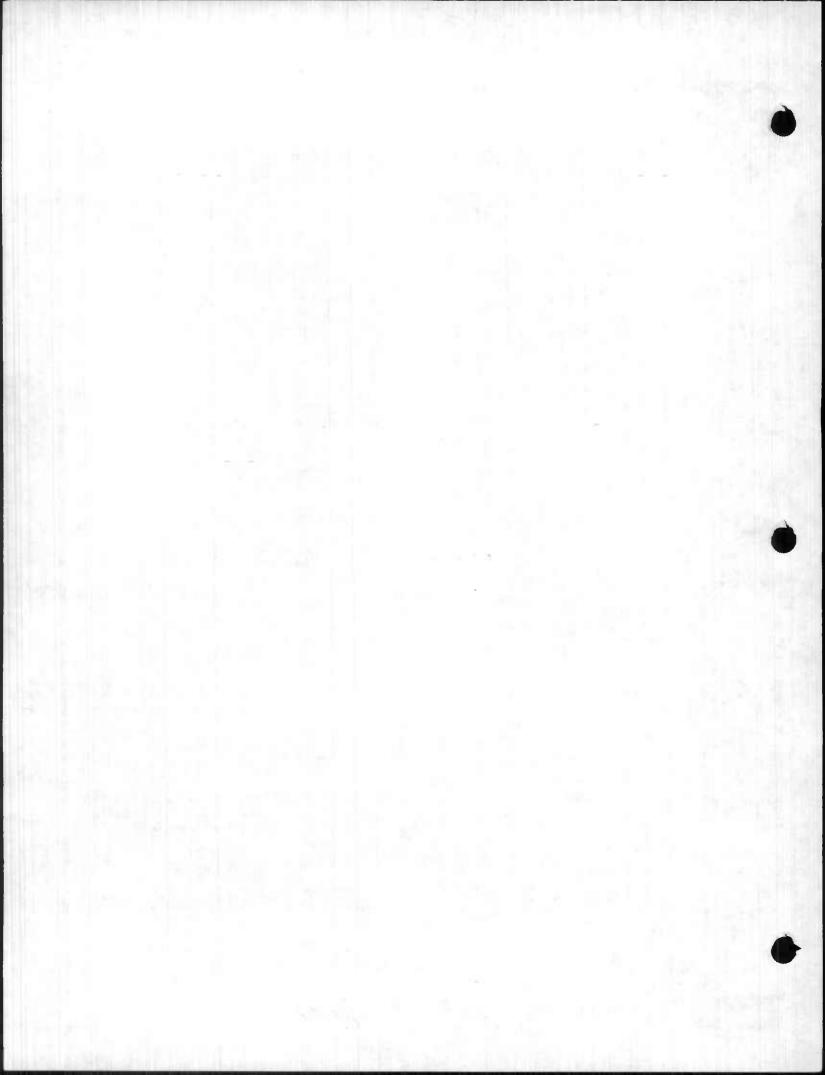
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State of Maryland / Department of Health and Mental Hygiene 0 1,797

			Ce	rtificate	of	Death		Re	eg. No.	0	112	Si col		
Physician	1. Decedent's Name (First, Middle, La						2	. Date of Deat Month	h Day	Year	3. Tima	of Death		
/Medical		Eric L.	Cooper					2	++	000	9 57	a.m.		
) Examiner	4e Facility Name (If not institution, given Johns Hopkins					Balti	imore	tion of Death	4c. County					
Funeral Director	5. Social Security Number 6. S 214-82-1996 Usual Residence of Decedent	7. Age (In 29	yrs. last birthday Yrs.	Months	Deys Deys	If Under Hours	24 Hrs. 8 Min.	Dete of Birth (Month, Dey, 9-8-1	Year) 1970	9. Birthp Cour	piace (Stet ntry) Md	e or Foreig		
P Au	10a. State 10b. County	100	. City, Town or L	ocation						1	10d. Inside	City Limits		
with the Maryland a or 28s-f show be notified at Director	Md N/	A	Baltimo						0.000			es 2 No		
ier death with the Maryle teems 22s or 28s-1 sho ner must be notified at Unneral Director					239				0g. Citizen of N					
Dy By By	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	in U,S. 13.	S. 13. Was Decedent of Hispanic Origin? (S If Yes, apecify Cuban, Mexican, Puerl 1 ☐ Yes 2 No Specify:					Specify	ck, White, y: B1	ack			
72 hz	15. Decedent's E		16a. Dece	edent's Usuel b kind of work	Occup	etion during mos	t of working	,	16b. Kind of B	usiness/In	dustry N	/A		
A LK 13-UUKU ed within 72 hours at yopiene, er then "natural", or it, the Medical Exam Compolated by I	Elementary/Secondery (0-12) 12th grade	College (1-4or 5+) N/A		Disabled		ratired)								
Tid Hyg d other event,							er'a Neme (First, Middle, M	Meiden Sumen	ne)				
Micro Victoria 2 should be file th and Mental Hy 7 is merked othe traumatic event						Tin	y Da)avis						
2 sho	19a. Informent's Neme/Relationship (own, Stete, Zip Code)				
- 在装衫上	Tiny Davis- Moth			9 Quan		o Ave	nue	Baltimo	ore, Md	2121	15			
dillimore, mil. Pages 1 a partment of Hsi portent: if item y injury or othe	20a. Method of Disposition Carried Carrie	Removel from State	b. Pleca of Disp cemetery, cre ing Memo	emetory or oth	her ple		2-		20c. Location - Randall			10		
Demit. Departmingorts eny inju	21. Signature of Funerel Service Licensee 22. Name and Address of Fecility March F/H West 4300 Wabash Avenue Baltimon										nore, Md 21213			
	23a. Part1. Enfer the disease, or com	plications that caused the								0 220	Approxim			
Physician /Medical Examiner	shock, or heart feiture. List only Immediate Cause (Final disease or condition resulting in death)	. BRONCH			BLI	TER	ANS			1	Intarval E	nd Death		
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been s should								24a. Was a parton		av cc	ere autopo vailable pri ompletion of t death?			
								1 🗆 Ye	es 2000	1	□Yes 2	2 No		
sician: The lay certificate has irector, page 2	25. Was case referred to medical				-	26 Plac	e of Deeth	Check only or	,					
Physician: this certific ral director.	examiner?	Hospital:	2 ER/Outpatie	ent 3 DO/	A Otl	her.				her /Snec	i6z)			
ding Physics After this funeral di		28e. Dete of Injury (Month, Day Yea	28b. Time		Bc. Inju Wo	Injury at Work? 1 Yes 2 No					77			
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be to	3 Suicide 6 Could not be determined	28e. Placa of Injury - At home, ferm, street, factory, office 28f. L					8f. Location (Street end Number or Rurel Route Number, City or Town, Stete)				lumber,			
To the Hospital within 24 hours. To the Funeral completely filled		ysician: To the best of my niner: On the basis of exar and menner steted.										ia(s)		
Me the	29b. Signeture end title of certifier			29c.	Licens	se number		2	9d. Date aign	ed (Month.	Day, Yea	r)		
F 3 F 8	· Sperllu	u		1) 2	8987			2/15/	00				
7	30. Name and sodress of officen who	completed cause of deeth FMD , 560	(ftem 23a) (Typa	H RAVE	SU	BLVD	BA	LPD. 1	MD à	11239	7	10		
State Registrar	31. Date filed (Month, Dev. Year)	32. Register's S	Signeture	9 A	on	K								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieng AMENDED DIEM 20b PER FH G780 2/16/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** CREDITT 1855 NELLIE 3 2000 FEB /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA HOWARD COUNTY GENERAL HOSPITAL HOWARD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Yrs Director 075-22-0624 09 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show thems 23s or 25s-f showing the neutron at XXYas 2 No Director MD Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 Ellicott death ' Funeral Drive 21216 U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 1 Yes WNO 21215-0020 r than "natural", or 1 Yes 2 No Specify Specify: P XXWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th grade NA Checker Eastern Overall Co. altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumeme) . Peges 1 and 2 should be fit ment of Health and Mental Hant: If Item 27 is marked oth lury or other traumatic even Be William McCoy Ethel Osborne

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Ethel Mickey-Daughter 7408 Sweet Clover Way, Columbia Md of Disposition (Name of Disposition (20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 2/18/2000 permit. Pege Department of important: If any injury or pnce. 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery -16-00 Baltimore Co, Md 21. Signature of Funeral Service Licens 22. Name and Address of Facility March F/H West 4300 Wabash Ave Baltimore Md 21215 Plan Peril: Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 4 hours disease or condition resulting in death) · ACUTE MYOCARDIAL INFARCTION Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Unknown RENAL FAILURE Records. 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Ther Division 1 Natural 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After completely filled in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 16 Rev 6/95

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31. Dete filed (Month, Day, Year)

PKWY,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNARD P. FARRELL MD

PATUXENT

32. Registrar's Signature

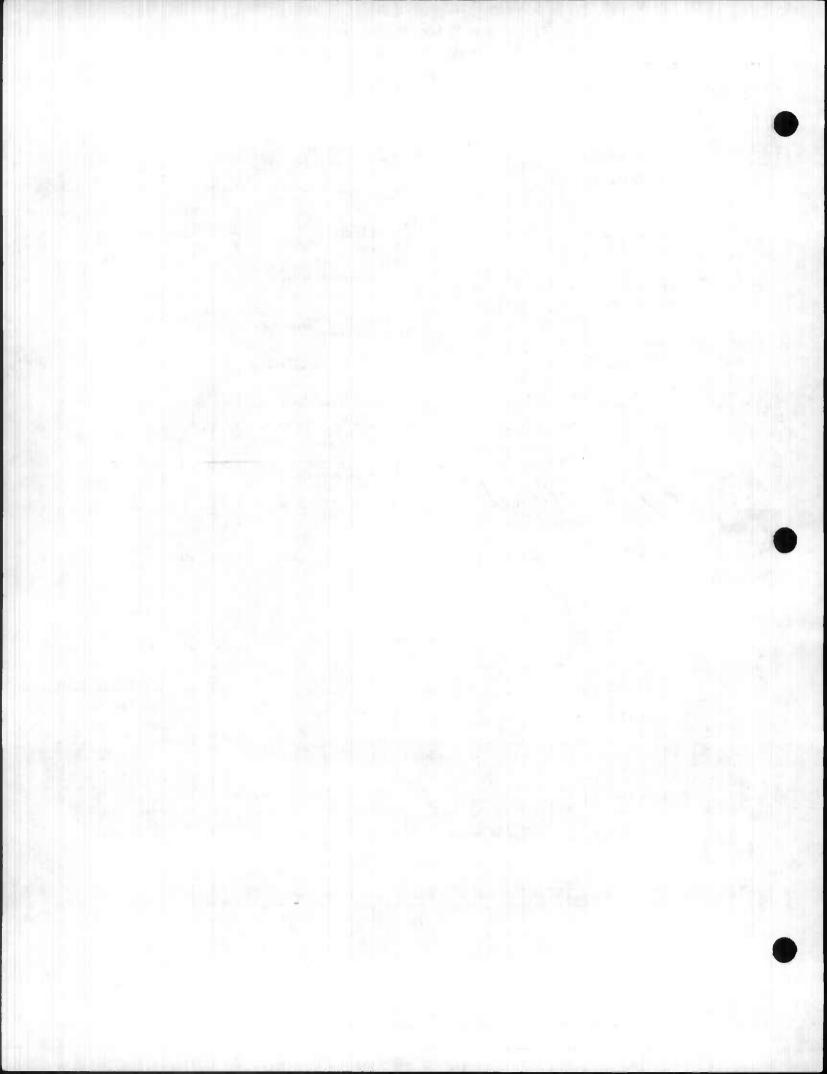
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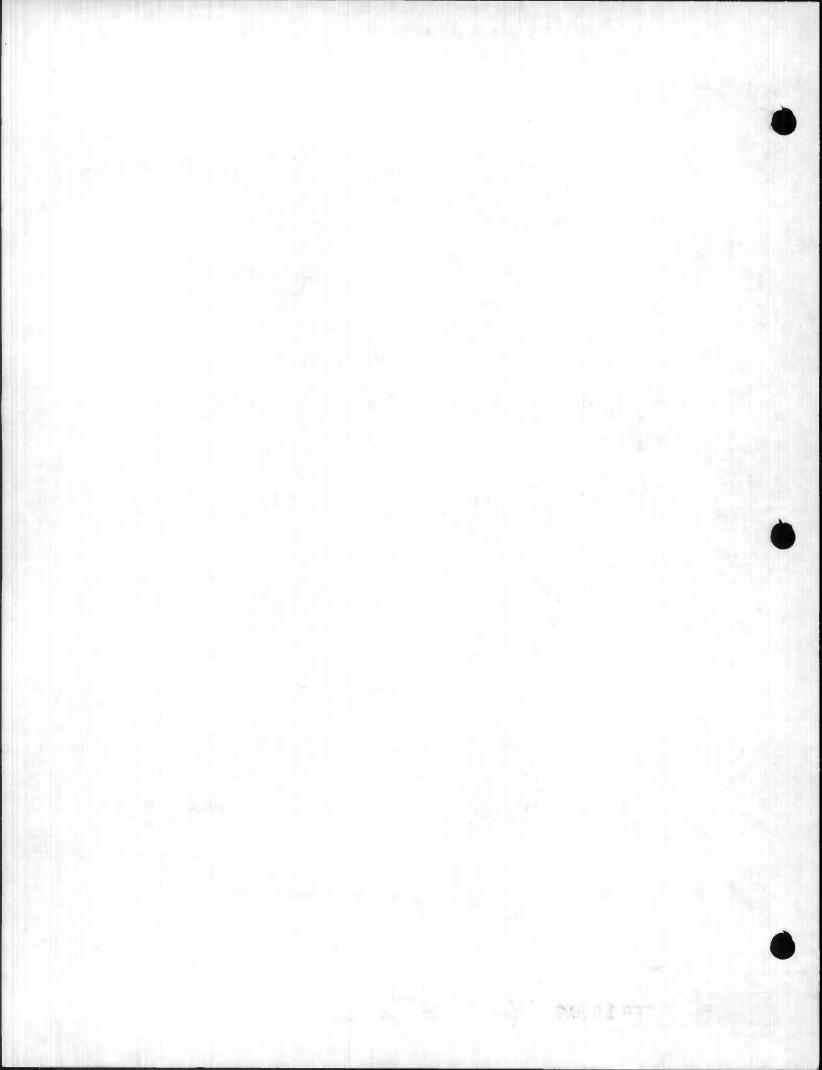


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Physicia	ın	1. Decedent's Nar	ma (First, Middle,	Last) Paul Aug	aust Co	onzeln	nann			2. Dete of De Month	Day Uary 10, 20	Yaar	3. Time of Death 8:02 am	
/Medica		te Facility Name	(If not institution, g			7112011			4b. City, Town, or L					
Examine	er	4a Facility Ivailie		521 Beechv						umbia				
uneral		5. Social Security		. Sex	7. Age (In yr.			1 Year	If Undar 24 Hrs.	8. Date of Bir	th Manal	9. Birth	pleca (Stete or Foreig	
irector		265-07-8		1 M 2 □ F		81 Yr	Months	Days	Hours Min.	8. Date of Bir (Month, De February	27, 1918	Cou	pleca (Stete or Foreignty) Germany	
ž	1	Usual Rasidence	of Decedent 10b. County		10c. C	City, Town o	r Location						10d. Inside City Limit	
i d	tor	Maryland	1	Howard				C	olumbia				1 ☐ Yes X ☐ N	
notifie	Director	10e. Street and No	umber				10f. Zi				10g. Citizen of	What Cou	ntry?	
		6521 Bee	echwood Driv	ve					21046			U.S.	Α.	
	by Funeral		rriad 2□kMerried 4□Divorced	Armed F	2 X No	U,S.	13. Was Dece If Yas, spe 1 ☐ Yes		tispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yas or No o Rican, etc.)	Specif	ck, White,	can Indian, etc. White	
the Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 5+						cedent's Usual Occupation we kind of work done during most of working e. DO NOT use retired Sales co-ordinator					s/Industry company	
D'	ပိ								18. Mother's Nam	ne (First, Middle	, Maiden Sumer	na)		
arkad o	To B		August	Conzelma	nn					Pauli	ne Conzelr	nann		
27 is ma r traum	-		Name/Relationship a C. Conzelr		Spouse	19b. A			and Number or Ru ood Drive Col				p Code)	
ury or othe			isposition 2 DCremation 3 1 5 DOther (Spe		Steta All	Plece of D cemetery, County	isposition (Ne cremetory or Crematic	me of other ple n Sen	vices, Inc. 02/	Date /11/2000	20c. Location Syke		own, Stata Maryland	
amy injury and injury		21. Signature of Funerel Service Licensee 22. Name end Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043												
ician		23a. Fart1. Enter shock, or he	the disease or co eart failura. List or	nly one cause on	eech line.				ng, such es cardiac	or respiretory a	arrest,		Approximate Interval Between Onsat and Death	
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te has	EO									1 🗆	Yes 2 No	1	TYPES 2000	
	Be	25. Was case refe axeminer?	erred to medical					10	26. Place of Dea	ath (Check only	one)		1	
6 =	2	1 ☐ Yes 20 27. Manner of De 1 ☐ Natural	5 Pending	28a. Dete (Mo			28c. injury at Work? 28d. Describe how injury occurred					ify)		
Director: J	Certification:	2 Accident 3 Suicide 4 Homicide Accident Accident									nd Number or Rurel Route Number, e)			
within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Cartifier (Check only one)		caminer: On the					ime, date and plece opinion, death occu					
To the	M	29b. Signafura an	nd title of certifier	/ 00					sa number		29d. Date sign	ed (Month	, Day, Year)	
X		•	Item.	Mellen	- lung			0130	61-B34613		Feb 10	,200	0	
()		30. Nama and add	dress of person w	ho completed cau	use of death (It	tem 23a) (T	ype, Print)		UNAPOLTS	0150	101101	. M	D 21042	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04800 Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Physician DE MINDS MARGARET ARU EDYUMY /Medical Location of Death Examiner More FUnder 24 Hrs. 8. Data of Birth (Month, Dey, Year) Min. MARCH 14, 1945 7. Age (In yes/ last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 216-42-7690 Usual Residence of Decedent 1 M 2 KF Hours Director MARULAND 10a State 10d Inside City Limits 10b. County 10c. City, Town or Location must be notified at BALTIMORE 1 Yes 2 No Directo MARYLAND 10f. Zip Code 10e. Street and Number 10g. Cirizen of What Country? STREET 742 2/21 USA 14. Race - Amarican Indian, Black, White, etc. PAL HOUN Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 210 No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other traumatic avent, the Medical Examiner Never Married 2 ☐ Married 6 1 Yes 2₺No Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced al Hygiene. Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 10 HAGRADE DEPARTMENT STOP SHOP & SAVE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked or CORNISH 0 JAMES DEMINDS 19b. Mailing Address (Street end Number or Reral Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremetory or other place) MONICA FORD (DAUGHTER STREET, BALTIMORE, MD.21217 Date | 20c. Location - City or Town, State altimoré, 20a. Method of Disposition 0 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 15-00 BALTIHORE, HARYLAND 22. Name and Address of Facility 21. Signature of Eugeral Service Licensee BROWN JR. FUNERAL HOME SEP 40 FULTON AVE. BALTO, MD. 2121 N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** Immediate Cause (Finel disaasa or condition rasulting in death) /Medical Examiner Examiner certificate be executed physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Ses 950 Po Furt II. Other algorificant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? detached P.O. 1 Yes 2 No 3 Probably 4 BUnknown signed t Division of Vital Records, Completed by 24b. Were autopsy findings eveilable prior to 24a. Wes en autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 After this 28a. Date of tnjury (Month, Dey Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation Hospital or Attanding 1 Naturel after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) Vithin 2 29d. Date signed (Mighth, Day, Year) 29b. Signatura and titla of certifiar 29c. License number ME Hull on. 30. Name and address of person who com cause oldeath (Item 226) (Type, Pa

Registrar

State

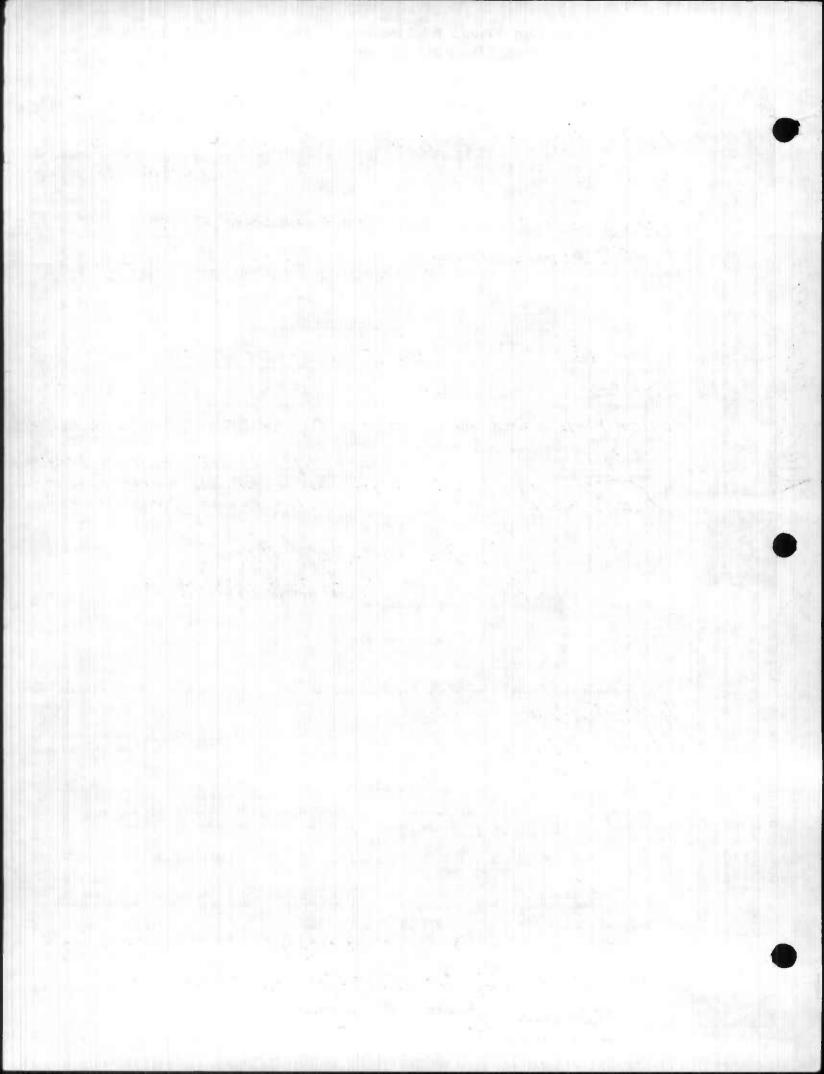
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32. Registrar's Signature

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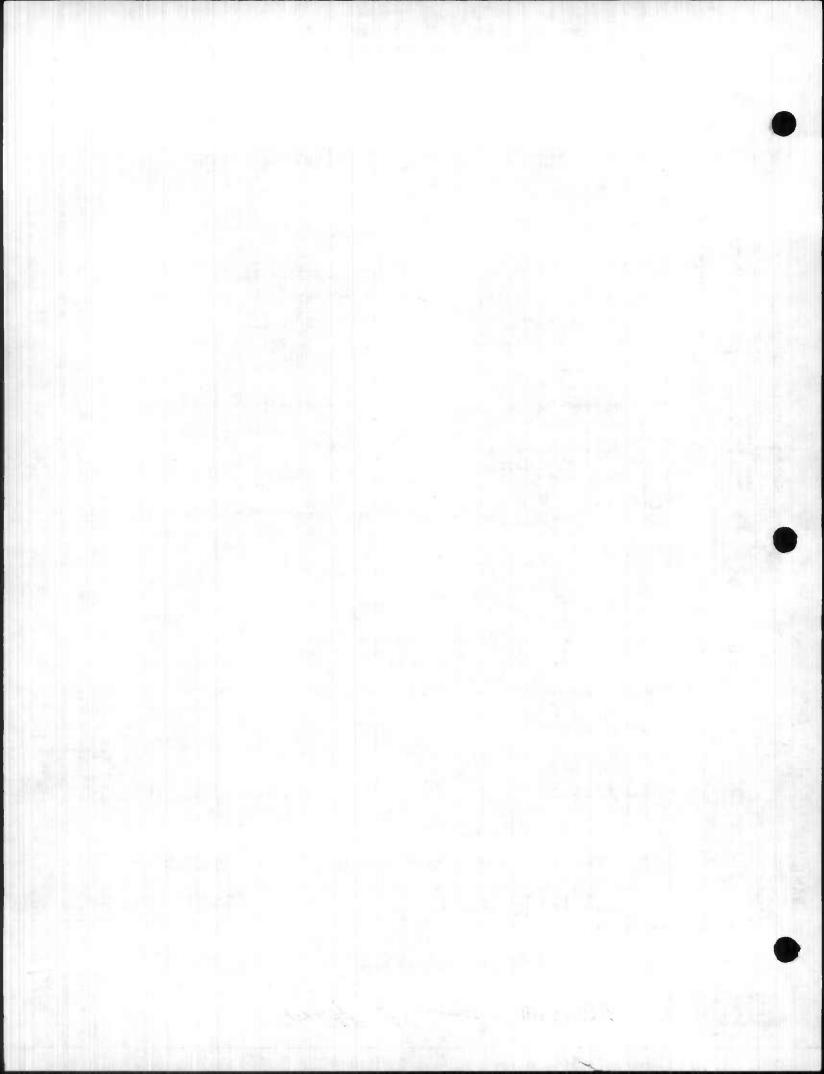
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	State of Maryland / Department of Health and M Certificate of Death	ental Hygiei Reg.	000	+801						
Physician /Medical	Decedent's Name (First, Middle, Last) Louis William Dash	FEB.	Day Year 4 2000	3. Time of Death						
Examiner Funeral Director	4a Facility Name (If not institution, give street and number) \$\int A \int N \int S \int O S P T \int \text{B \int N \int B T \int M \text{City, Town, or Lot \int B \int T \int M \text{S \int N \int B \int D \int B \int T \int M \text{S \int N \int B \int D \int B \int T \int M \text{S \int N \int B \int D \int B \int	8. Data of Birth (Month, Day, Ye May 15,		place (State or Foreign ntry)						
	Usual Residence of Decedent	nay 15								
n the Marylan r 28a-1 show notified at	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ②No						
vith the Mai s or 28a-f s be motified Director	Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Code	10a.	Citizen of What Cou	ntrv?						
23a or matthe	1213 Birch Avenue 21227		United Sta							
ter death with team 23e or free must be	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ameri Black, White,	can Indian,						
020 urs after death v in; or items 23s	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ② No Specify:		Specify:							
aryland 21215-0020 should be filed within 72 hours after death with the Maryland and Mental hyglene. Improve order than featurel; or items 23s or 28s-f show unraftic event, the waster feature must be notified at To Be Completed by Funeral Director	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16h	Wh:	ite						
ind 21215-00 be filed within 72 hot tal thygiene. To other than "natural work, the manaral Be Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	ng	. Italy of Downson	out y						
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ore, Maryland 2 es 1 and 2 should be filed of Heelin and Mental hygi filem 27 is marked ather of other traumatic event, To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maid	den Surname)							
Tyla nould I Men To To		Batzer	T	Codel						
Ma and 2 sl sellth and n 27 is n er traur	19a. Informant's Name/Relationship (Type, Print) Grace Dash (Wife) 19b. Mailing Address (Street and Number or Rura 1213 Birch Avenue Arbu) Cooe)						
s 1 an other other	20e. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)		Location - City or To	own, State						
Pages nent of it	1 KI BURIA 21 I Cramation 31 I Removal from State	/17/00 B	altimore,	Maryland						
Baltimore, permit. Pages 1 ar Department of Hea Important: if item? any injury or other once.	21. Signature of Funeral Service Licensee Ambrose Funeral Home Ambrose Funeral Home		utus MD (21227						
Physician	23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest,		Approximate Interval Between Onset and Death						
/Medical Examiner	Immediate Cause (Final disaasa or condition resulting in death) a. ASPIRATION PNEU Due to (or as a consequence of):	MUNIA		1WEEK						
8 % %	b. CVA		1	19tAK.						
8760, cate be executed bhysician and the burishmentit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):									
OX 6 certific certific use as	resulting in death) Last Due to (or as a consequence of): d.									
To the state of	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?								
is, P.O. as that the de general by the selection by Physic		1 Yes	2 No 3 ₽ro	bebly 4 Unknown						
ecord aw requir is been s 2 should pleted		24a. Was an ar performed	1?	fere autopsy findings vailable prior to ompletion of cause death?						
The law The law page 2 s		1□ Yes	200 No 1	☐ Yes 2☐ No						
f Vital F Ystelen: The yelden: The Se centificate director, page	25. Was case referred to medical examiner?	(Check only one)								
T will be T		me 5 Residence	6 Other (Speci	<i>fy)</i>						
On o oding Ph of the the funeral	27. Mannér of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 4 Work? 1 No Natural 5 Pending (Month, Day Year) 1 Yas 2 No	EUG. DESCRIBE NOW I	iquiy occurred							
AME / Division Division pital or Attending oral site death. eval Director: After filled in by the fune	a Could not be	281. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,						
NAME Constitution of Division of To the Hospital or Attending Particles and Safer Seath completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a common one) 1 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.									
Within To the compl	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)						
	MEDICAL RESIDENT P13602	Į į	EB. 141	2000						
17	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NR BARIFI OPARE - ADAD 2502 W PATAPS Q AVE2B	BALTIM	ORE MD	21230						
State Registrar	31. Date filed (Month, Day, Year) FEB 1 6 2000 Server & Spark									

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent'a Name (First, Middle, Last) 4b. City, Town, or Location of Death 4c. County of Death de If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Days 10 M 2 F Yrs. 41 July 02 1958 Maryland 213-72-5492 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Anne Arundel Co. Pasadena 1 Yas 3 No 10f. Zip Coda 10g. Citizen of Whet Country? U.S.A. 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 27 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Bausman Duckett Co. electrician 0 18. Mother's Neme (First, Middle, Melden Sumeme)

death with the Marylend ir than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Director 10e. Street end Number 950 Longview Ave. Funeral 11. Maritel Status pemit. Pages 1 and 2 should be filed within 72 hours effer a lopparment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat 1 Never Married 2 Married Saltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Fether's Name (First, Middle, Last) Charles J. D'Alfonzo 19a. informent's Neme/Relationship (Type, Print) Sharon L. D'Alfonzo (Wife) 20a. Mathod of Disposition 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarel Service Licensee 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest,

Approximately a such as cardiec or respiretory arrest,

Physician /Medical

Examiner

10a. Stete

Md.

Funeral

Director

Joan A. Wengert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 950 Longview Ave. Pasadena, Md. 21122

20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State Glen Haven Memorial Park 2/15/00 Glen Burnie, Md.

Velton

22. Nama end Address of Facility McCully-Polyniak Funeral Home P.A.

Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of):

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last

Due to (or as e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Approximete Interval Between Onset and Deeth

24a. Wes en autopsy performed?

24b. Were eutopsy findings available prior to completio n of cause 20 No 20 No

29d. Date signed (Month, Day, Year)

25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) examine 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 EN Outpatient 3 DOA 1 Inpatient 27. Mender of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 1 Naturel 5 Pending 2 No 1 ☐ Yes investigation

2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and matter. On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature

on who completed cause of death (Item 234) (Type, Print

Box 68760 P.O. Division of Vital Records.

Physician

/Medical Examiner

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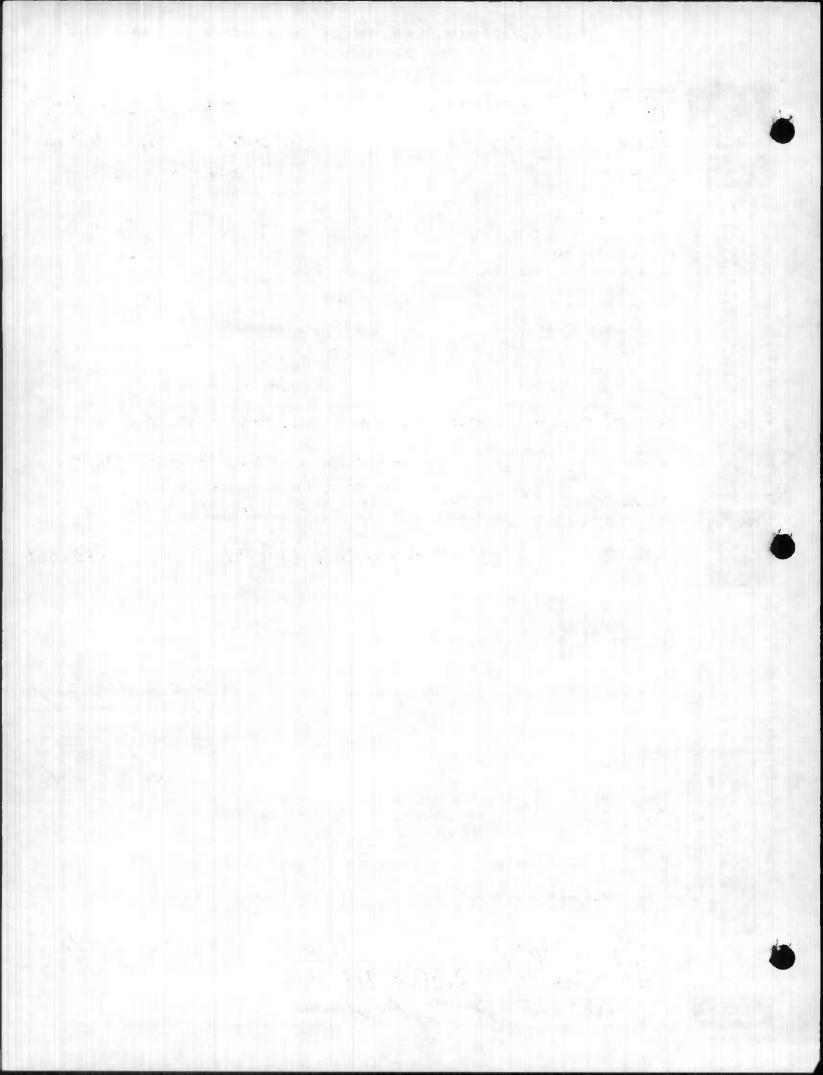
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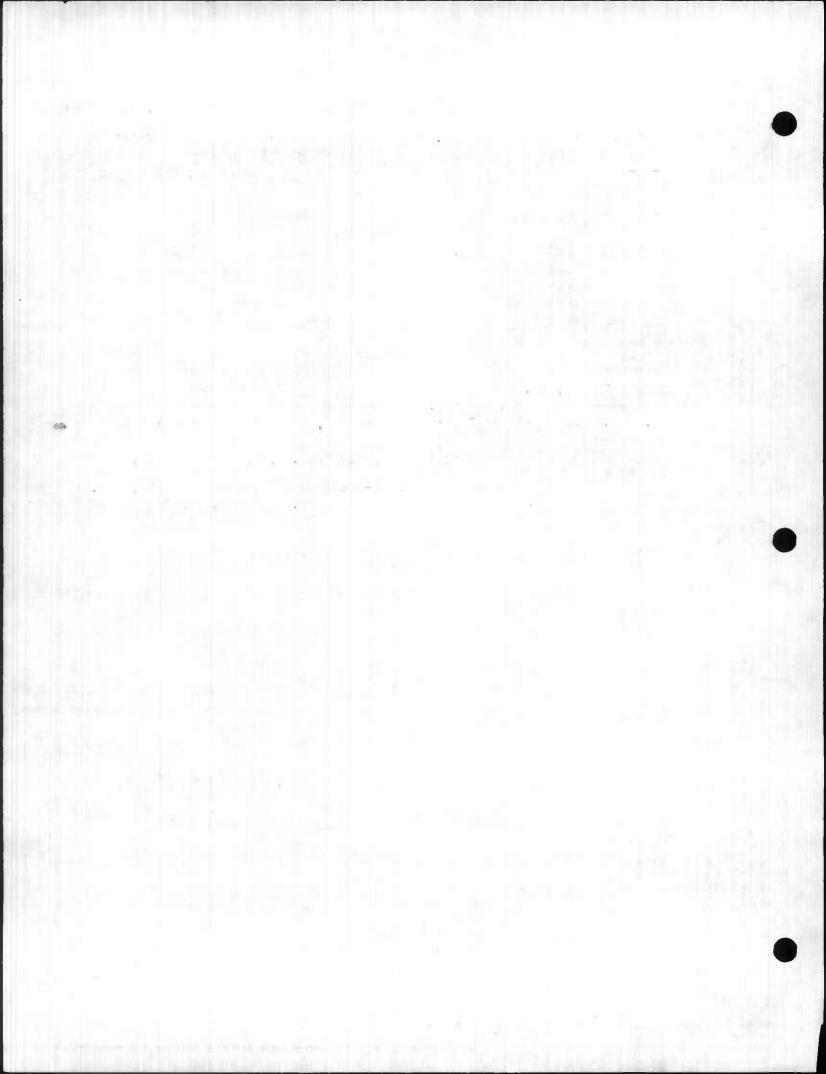
State Registrar



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State of Maryland / Department of Health and Mental Hygiene 0 14803

				Certifica	ate of	Death		Reg. No.	U I	1000		
Physician	1. Decedent's Name (First, Middle, L.						2. Date of De-	ath Day	Year	3. Time of Death		
Physician /Medical		Sandra	Kay	Ι	Dowel]		Februa		2000	4:15 AN		
Examiner	4a Facility Name (If not institution, gi	ive street and number)				4b. City, Town, or	Location of Death	4c. County	of Death			
	11 Glenwood Roa	id	Apt. C			Essex		Ba	altimo	ore		
uneral irector	5. Social Security Number 8. 217-62-3072	Sex 7. Ag 1 ☐ M 252 F	e (In yrs. last bir 46	Yrs. If Un Monti	der 1 Year hs Days	If Under 24 Hrs Hours Min		th Y. Year) 0,1953		lace (State or Foreign try) cyland		
	Usual Residence of Decedent											
rector	Maryland B	altimore	10c. City, Town	n or Location		Essex			10	0d. Inside City Limits 1 ☐ Yes 2 ② No		
Funeral Director	10e. Street and Number 11 Glenwood Roa	d A	pt. C	10f.	Zip Code	21221		10g. Citizen of United		•		
à	11. Merital Status 1 □ Never Married 2 □ Merried 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 253 If Yes, Give Year or Detes:			cedent of Hispecify Cubi	tispanic Origin? (s an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
P	15. Decedent's E		16a.	Decedent's U	sual Occup	pation	arkina	16b. Kind of B	usiness/Ind	lustry		
Be Completed	(Specify only highest gr Elementary/Secondary (0-12) 8 Years	College (1-4or 5+)		Cashie		nd of work done during most of working O NOT use retired) hier		Re	Retail			
O	17. Father's Name (First, Middle, Las	t)				18. Mother's Na	me (First, Middle,					
ToB	Samuel Clemons, Sr. Helen Stor											
F	19a. Informant's Name/Relationship		ahterlien	Mailing Adds	acc (Street				State 7in	Codel		
To Be Col	Mrs. Stephanie	/ -	_				cle Edge					
į	20a. Method of Disposition		20b. Place of	Disposition (i	Name of	cel	Date	20c. Location	- City or To	wn, State		
5	1 Burial 2 SCremation 3 [4 Donation 5 Other (Special Control of the Control of t					Corp. 2/	14/00	Towson	n. Mar	rvland		
	21. Signature of Funeral Service Lice			-		_	-700	2011001	.,	7 2 41.4		
9	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222											
	23a. Part 1. Enter the Ohease, On con shock, or heart failure. List only	iplications that caused y one cause on each li	I the death. Do r	not enter the m	node of dyir	ng, such as cardia	c or respiratory a	rest,		Approximate Interval Between		
an	Onset and Death											
at												
H.	disease or condition resulting in death) Due to (large a consequence of):											
b	I schemic myocardial disease									3		
튵										3 years		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.											
	Cause (Disease or injury	е					i					
adical	that initiated events resulting in death) Last		Due to (or as a c	onsequence o	of):							
ž	L	4						i				
by Physician/	_	4		_					1			
0	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlyin	g cause giv	ven in Part I.	23b. Did 1	lobacco use co	intribute to	the cause of death?		
ty	1	-1					100	pably 4 Unknow				
Y	L'agentes ou	ung					7	Yes 2 No				
P	,	_					24a. Was	an autopsy	24b. We	ere autopsy findings		
Completed							perfo	med?	COL	nilable prior to repletion of cause		
dr.									of c	death?		
3							101	res 2 No	10	Yes 2□ No		
Be	25. Was case referred to medical examiner?					26. Place of De	eth (Check only o	ne)				
To	Yes 2 No	Hospital:	nt 2 ER/Ou	tpatient 3	DOA Oth	ner: 4 Nursing I	Home 5 Aesid	ience 8 □Ott	ner (Specifi	()		
	27. Manner of Death	28a. Date of Inju (Month, Day		ime of	28c. Injur		28d. Describe I					
윺	1 Neturel 5 Pending 2 Accident investigation		rear) II	njury M		Yes 2 □ No						
Certification:	3 Suicide 4 Homictde 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)											
edical		hysician: To the best of miner: On the basis of and manner sta	examination and									
Me	29b. Signature and title of certifier	Δ			29c. Licens	e number		29d. Date signe	d (Month	Dev. Year)		
		/\	ml					200	1 40			
	V. Crossun O	tonoran,	17. P.		170	7632		LED	10)	2000		
	30. Name and address of person who	completed cause of di		Type, Print) 2111	Duns	DALK A	VE, BI	OF LTO	(Im	21222		
tate	31. Date filed (Month, Day, Year)		ar's Signature	1	1							
State		00	a display	M A	na H	1						



February 11,2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8 Date of Birth (Month Day Year) NOV. 25, 1920 7. Age (In yrs. last birthday) **Funeral** Months Days 1XX M 217 F 215-18-7518 79 Yrs. **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Baltimore Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 8114 Thorton Rd. 21204 23a USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ⊠ Yes 2 No If Yes, Give WW II Year or Dates: Maryland 21215-0020 1 ☐ Yes 2XNo Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer C&P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be le merked Milton A. Davis, SR. Edith Seipp 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20115 M. Thomas Davis / Son 8114 Thorton Rd. Towson MD, 21204 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removel from Stete 2/15/2000 Pikesville Druid Ridge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Dennis C. Caproll Ruck Towson Funeral Home Inc. aua 1050 York Rd. Towson MD. 21204 23a Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest block, or heart failure. List only one cause on each line. **Physician** immediate Cause (Final disease or condition resulting in death) /Medical Examiner

1. Decedent's Neme (First, Middle, Last)

Milton Amor Davis

Physician

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

9. Birthplace (State or Foreign

Baltimore, MD

White

10d. Inside City Limits

Approximata Intervat Between Onset and Death

3 Probably Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2XXNo

10:37 pm

Box 68760. P.O. Records,

Division of Vital

Physician/Medical þ should be d Completed certificate Physician: Be Certification: To After this or Attending death. 24 hours after deal Funeral Director:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 24a. Was an autopsy performed? 2000 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 1 Natural 5 Panding 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State

Medicai

Registrar

29b. Signeture end title of cartifie

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who comp a) (Type, Print)

FEB 1 6 2000

32. Registrar's Signature

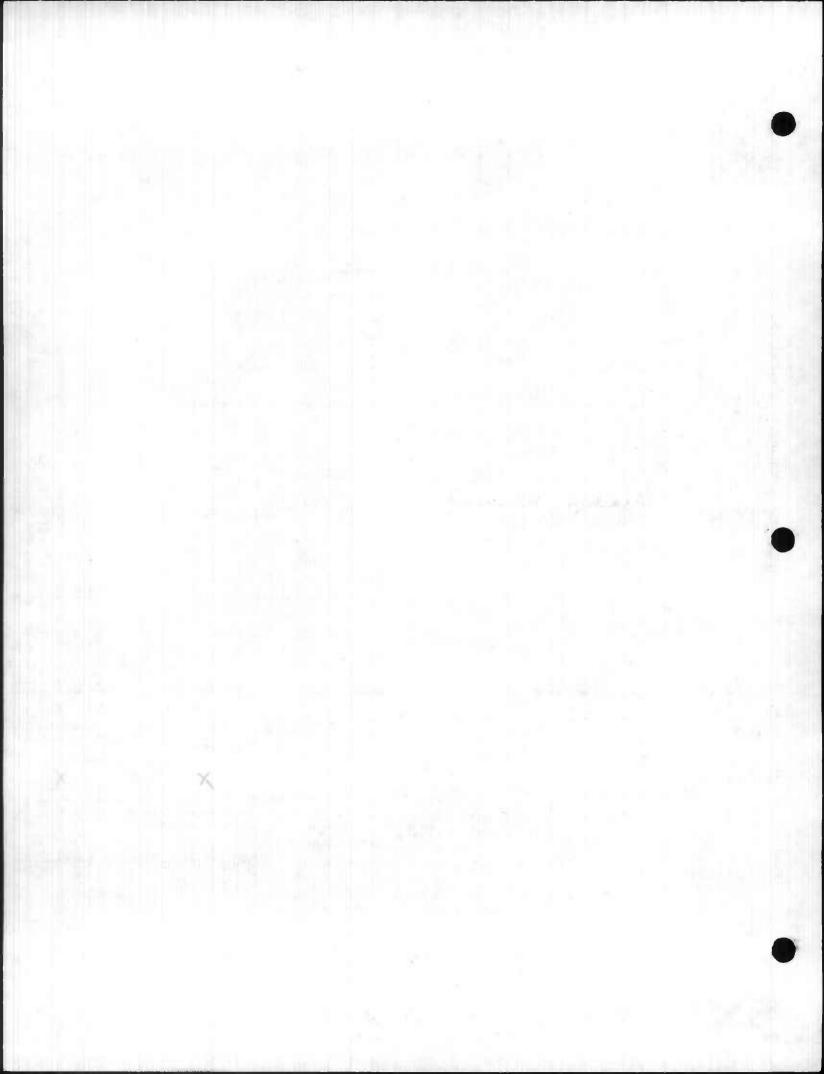
DHMH 16 Ray 6/95

within 2 To the 945

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** February 17 cdmon Emma 07:40AM 14 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BA HIMORE City KINS THE JOHN 5. Social Security Number | M Under 1 Year | M Under 24 Hrs. | 8. Date of Brith (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2⊠ F Yrs. Director 214-26-7324 07-28-18 NC Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD NA 1 QYes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 1613 North natural, or flams 23a Rutland Avenue 21213 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: py Black 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) 6th Grade College (1-4or 5+) NA Domestic various trades 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked of Mariah Robert Vincent Eaton 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Department of Health ar Important: If Itam 27 is any injury or other treat Gladys Demonds 1613 N. Rutland Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 02-19-2000 Dundalk, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Maryland 21202 Glady Wans WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final D'isease disease or condition resulting in death) Examiner Examiner and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Brain Mass 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Completed Carotid Stensis - Critical completion of cause of death? 1 ☐ Yes 2 No 2 No after death.

Director: After this certifica 86 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No edicai Certification: To 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Naturel
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion n 24 hours after det ne Funeral Director pletely filled in by th 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. To the I 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 000 wary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Baltimore Sherwin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB16 2000 Registrar **DHMH 16 Ray 6/95** 5000

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death **Physician** 1700 19,2000 Jan. DONZELLA HEDD) /Medical 4c. County of Deeth 4b City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner DEATION SPECIALTY HOSPITAL & HOME BALTIMURE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign 1□M 2×F Months Deys 555 Director 10c. City, Town or Location 10a. Slate 10b. County 10d. Inside City Limits Ves 2□ No YARdans none Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itema 23s or edical Examiner must be 1422 21217 DIVISON 4517 Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yas, Give Year or Dates: Bieck, While, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Amorican 10 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owis Home tome maker nme 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Lon Ald ERA Cobe Coby Mormant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Divison Street med 21217 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition Burial 2 Cremation 3 Removal from State 22. Name and Address of Fecility Ancey Son um of Funeral Service Licensee 3405 W. DRANKlin St. BAHAMORE. exeldee disasse, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or than feiture. List only one cause on each line. Approximete Interval Between Onsel end Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical CHRONIC RENAL INSVIPFICIENCY Examiner Examiner SUBSTANCEABUSE Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Completed by Physician/Medical Due to (or as a consequence of) Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Miknown ADS, SEIZURE DISORDER, LVH, WASTING 1 ☐ Yes 2 ☐ No & DECONDITIONING, "TO LEG ULCERS, HEPATITISC 24b. Were autopsy findings evailable prior to 24a. Wes an autopsy performed? completion of cause of death? NO ENTEROCOCCIL BACTEREMIA 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpetiant 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturai 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 Destilying Physician: To tha best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. xaminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 MedicaLE

Box 68760,

I a marked other than "nature traumatic event, or Medical

Registrar

31. Date filed (Month, Dey, Year) FFB16

29b. Signeture and title of

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

The Mulan MD, 29 S-Greene Street, swite 300, Ballimore MD, 2120 32. Registrar's Signature

MD

29c. License number

D52394

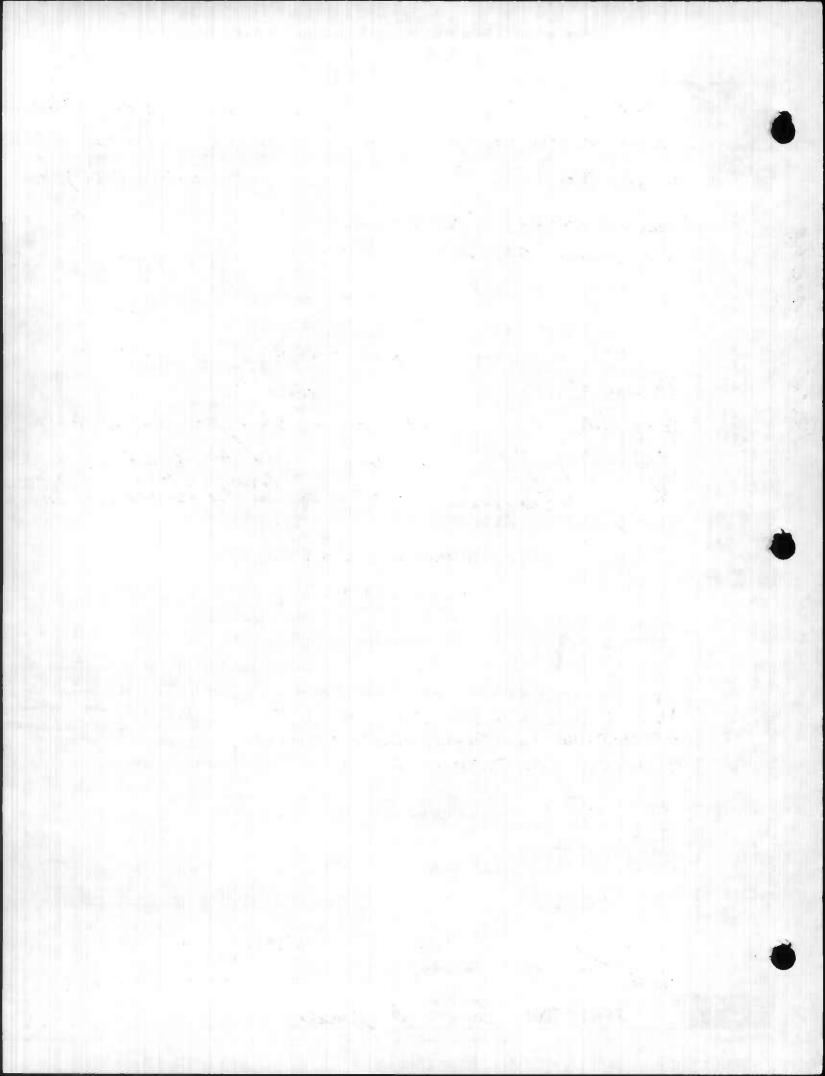
29d. Date signed (Month, Day, Year)

1-21-00

DHMH 16 Ray 6/95

24 hours efter death.

within 2 To the



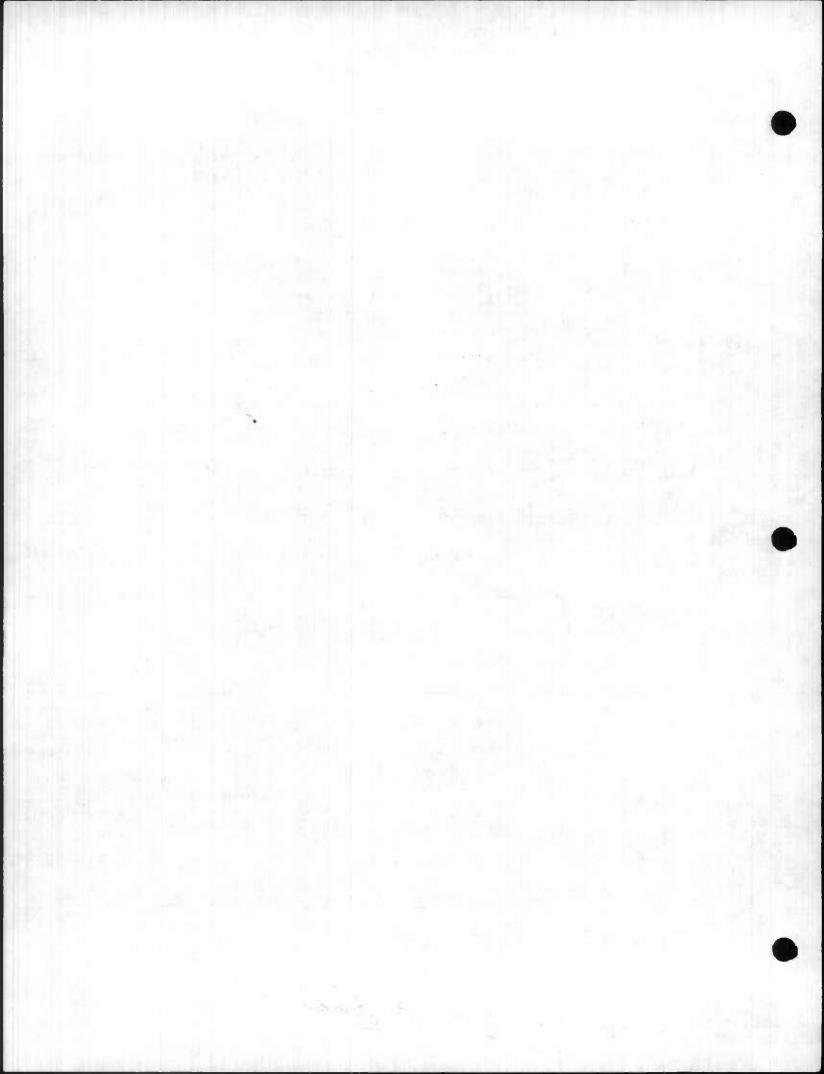
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ANICE 7:45 PM FORD ROBINSON 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE TIMORE IA If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 6 Sax 7. Age (In yrs, last birthday) **Funeral** Days Months 225-44-90 11 Usual Residence of Decedent 1 □ M 20 F 63 Yrs. Director IRGINIA 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show 1⊠Yes 2□No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVENUE Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2/9 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 28 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MASTERS DEGREE TEACHER BALTO. CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental JACOB CARRINGTON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Reral Route Number, City or Town, State, Zip Code) or other tra BALTIHORE, MD. 21215 KEV. HERMAN A. FORD (HUSBAND) 5813 STUARTAVE. altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State Date 20c. Location City or Town, State permit. Pege Department of Important: If any Injury or RIDGE CEMETERY 12-17-00 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee H. BROWN EPH 40 FULTON MD. 2121 N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Approximate tritervat Between Onset and Death **Physician** /Medical Immediate Cause (Final colon 22 months CANCEY disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be axec Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 XNo 3 Probably 4 Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was casa referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) to spice edical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 5 Pending investigation Division 1 Natural 2 Accident 1 Yes 2 No To the Hospital or Attendition 24 hours after death.

To the Funeral Director: A death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) no 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) Balto 6701 31. Date filed (Month, Dey, Year, 32. Registrar's Signature State Registrar FEB 1 6 2000 **DHMH 16 Rev 6/95**

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04808 Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month 3.10 pm Frank James Fenyes 2000 CP 4a Facility Name (If not institution, give street and number) 4b_City, Town, or Location of Death 4c. County of Death Hospira More Agnes If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Months Days Hours 1☑ M 2□ F 78 213-14-5434 08-13-1921 Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Arbutus Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1204 Seven Oaks Rd. 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forcas?

1 ⊠ Yes 2 □ No If Yes, Giva 0 7 − 28 − 44 Year or Dates: 02 − 12 − 46 Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian 11. Meritel Stetus Black, White, etc. 1 ☐ Navar Married 2 ☑ Merried 1 ☐ Yes 2 ☑ No Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Defense 18. Mothar's Nema (First, Middle, Meiden Sumame) 17. Fathar's Nama (First, Middle, Last) Louis Fenyes Germaine Meche 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte M. Fenves 1204 Seven Oaks Rd. Arbutus, MD. 21227 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Crametion 3 ☐ Ramoval from State Garrison Forest 02-15-00 Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Nama and Addrass of Facility
Ambrose Funeral Home, Inc. 21. Signeture of Funaral Sarvice Licensia 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete tntarval Between Onset and Death Immediata Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequenca of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Jast 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yas 1 Yas 2 No 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidenca 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 | Yas 2 | No

of Vital Tens Division

Physician/Medical g Completed Be 2 Director: After death. 24 hours a

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

Funeral

Director

then "natural", or lisms 23s or 28s-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Nem 27 is married offer than "n Inty Injury or offer treasment of other than "n

Physician /Medical

Examiner

Fran

Medical completely To the To the To the F

25. Was casa refarred to medical axaminar? 1 Yas 2 No 27. Manner of Death 1 Netural 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. (Check only one)

Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the causa(s) and manner stated. 29b. Signeture and titla of or

GENTADO

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and addrags of person who completed cause of death (Item 23a) (Type, Print) Dem 4

13596 2000 900 Caton Ave Bolkmore, MD 21229

State Registrar

31. Data filed (Month, Day, Year) FEB 1 6 2000 32. Registrar's Signatura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month 2310 Washington February 2000 Saltmore
Il Under 24 Hrs. 8 /Medical 4a Facility Nama (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITA 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, 2-22 9. Birthplaca (Stata or Foreign **Funeral** 1MM 2DF Days Months Director Ma 16-22-4689 Usuel Rasidence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits t then "naturel", or heme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No WA Director more 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 0.3 Hvenne 41207 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ✓ Yes 2 ☐ No If Yes, Giva Was Decadent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Black, Whita, atc 1 Never Married 2 Married 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify: þ NYes, Gru Year or Dates: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiens. Important: if ham 27 is marked other than "naturary injury or other traumatic avaired." 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) th a rad tand/er 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be John 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) TOWK Ho, med 21207 0 enu 110 150 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stata 4,115,19 Ver Donation 5 Other (Specify) toris 2-18-00 00 22. Nama and Addrass of Facility 21. Signature of Funaral Service Licensee 300 Wibas No, MA 23a Part1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death tha moda of dying, such as cardiac or raspiretory arrest, **Physician** 30min /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Examiner physicien and the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yea 2 ☐ No þ 24b. Wara autopsy findings evailable prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yas 2 No To the Mospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to 8 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Yas Certification: To 2 No 1 Inpatient 2 XER/Outpatient 3 DOA nnes of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Medical 29a. Certifier (g) Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature anth/titli 29c. Licensa number 29d. Data signed (Month, Day, Year) oldeath (Item 23a) (Type, Print) MI Wi m

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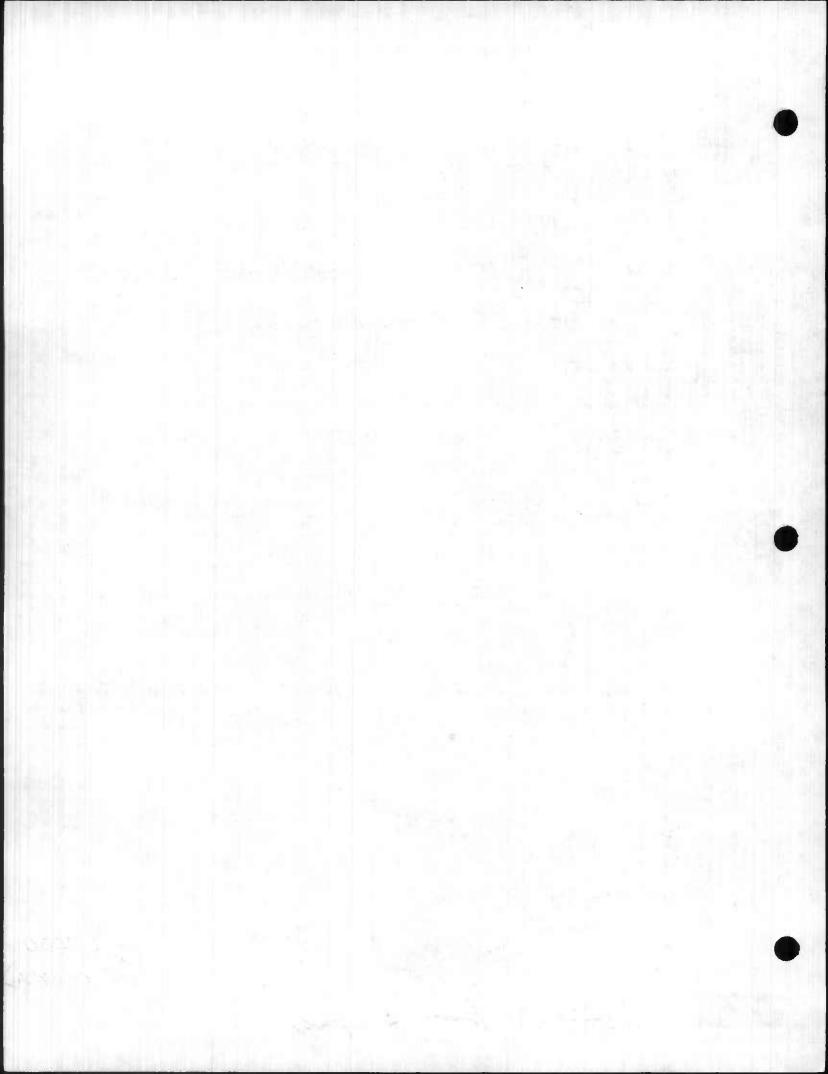
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32. Registrar's Signatura



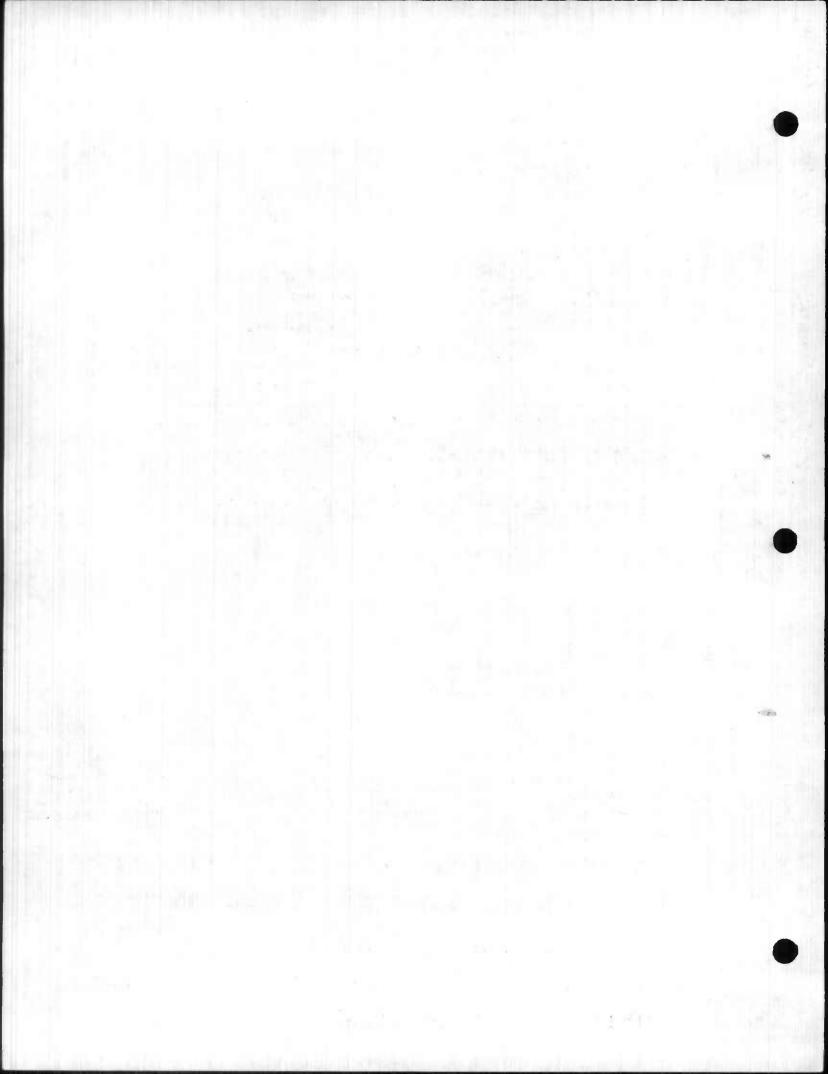
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Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** LOIS JOHNSTON FUNK FEB. 14 2000 3:42pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Ye 5. Social Security Number ar If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/31/1912 Birthplace (Steta or Foreign Country) **Funeral** Davs Hours Months 1 M 2 F Yrs. 214-46-8521 87 Director MARYLAND Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits BALTIMORE TOWSON 1 ☐ Yas 2 No Directo 288-1 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? b 6565 N. CHARLES ST. 21204 USA Nerns 23a Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 □ Yea 2 図 No If Yes, Give Year or Detea: Waa Decedent of Hispanic Ongin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merned natural, or 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4yrs HOMEMAKER HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) B Pages 1 and 2 should be nert of Health and Mental EDWARD E. JOHNSTON ELLA STRAN JONES 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. NORWOOD FUNK (HUSBAND) mportant: If Item 27 iny injury or other tr 1055 W. JOPPA RD. TOWSON, MD. 21204. 20a. Method of Disposition 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GREEN MOUNT CREMATORY02/16/2000 BALTO., MD. 21. Signature of Funerel Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel renal disease or condition resulting in death) Examiner ician and buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical å. Due to (or es e consequence of) 085 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributé to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ HO or Attending Physician: funeral director, 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Stener (Specify) 1/05 PICE Certification: To 1 Yes 2 No this 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending invastigation 1 Neturel within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled In by 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end mannar stated. edical 29a. Certifier completely (Check only 29b. Signature and title of coddline 29c. License number 29d. Dete aigned (Month, Day, Year) clans mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Touson MD 21204 no Charles St. Adams 6565 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

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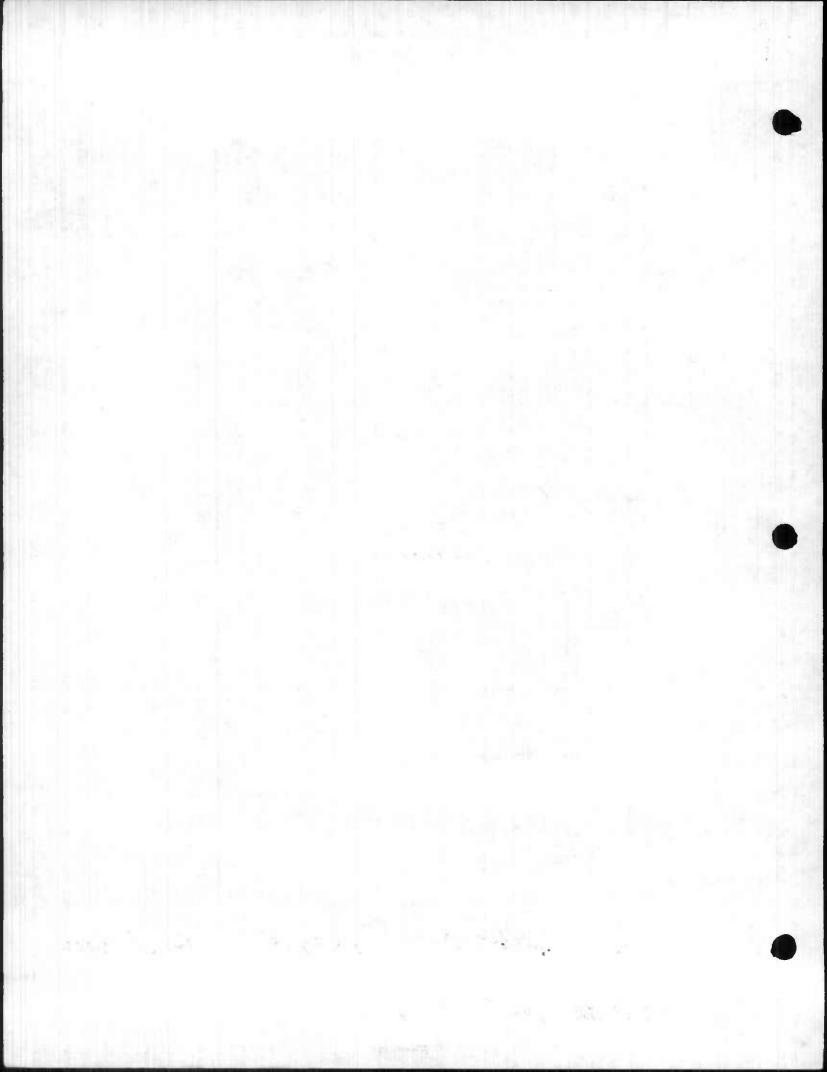


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State of Maryland / Department of Health and Mental	Hygiene ()	048	
Certificate of Death			

				Certificate	of L	Death		Reg. No.		
	1. Decedent's Name (First, Mic	ddle, Last)	THE HOLD				2. Date of		W	3. Time of Death
Physician		Daniel	Leroy Fre	v			Month	Day bruary 9, 20	Year	4:40 pm
/Medical	4a Facility Name (If not institut			,	4	b. City, To	wn, or Location of De	ath 4c. Cour	nty of Death	
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or 28e-f s be notified Director	10e. Street and Number			10f. Zip C	ode			10g. Citizen o	of Whet Cou	intry?
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marked marked martic er	-	niel Brown Frey						Addie Fife		
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Department important: any injury once.	21. Signature of Funeral Servi	ce Licensee		22. Name and	Addres	s of Fecilit	у			
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al dire	1 Yes 2 No	Hospital: 1 🗆 Inj			-	4LANE	ırsing Home 5□R	esidence 6 🗆	Other (Spec	city)
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(Y)	30. Name and address of pers				Cal	umbia A	4D 21044			
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6121 Montroe Road Rockville, Maryland 20852

icien and buriel-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ettending physicien for usa as tha burie signed by the e been sign has cartificate or Attanding Physician: diractor, 24 hours after death.

Funeral Director: After this etely filled in by the luneral di To the F

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Important II fem 27 is marked other than "na any injury or other traumatic event, the Medic one.

Physician /Medical

Examiner

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Physician/Medicai

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Certification: To

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72 hours after death

filed within 7 Hygiene.

Baltimore, Maryland 21215-0020

Registrar

FEB 1 6 2000

31. Date filed (Month, Day, Yeer)

wilksmo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hebrew Home

32. Registrar's Signature

Washington

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BHMH 16 Rav 6/95



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e Type or Print in Bia	ack indelible ink. Assure	All Copies Are Legi	Die.
State of Maryland	/ Department of Health and	Mental Hygiene	01.813
	Certificate of Death	Reg. No.	04010
Last)		2. Date of Death	3. Tima o

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permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Meryland Department of Hasith and Mentel Hyglene. Important: if frem 27 is marked other than "natural", or Hems 23s or 28s4 show Baltimore, Maryland 21215-0020

Physic /Med Exam

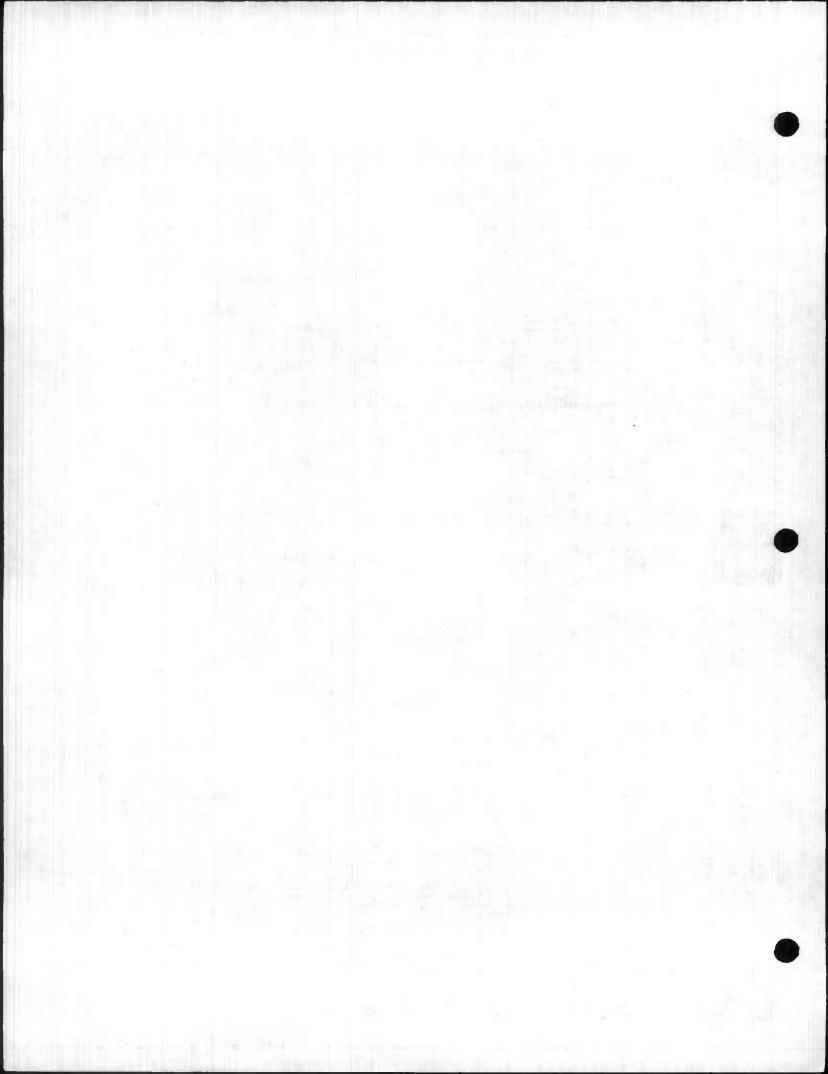
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The lew requires that the death certificate be associted within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and

	3. Time of Dea
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10a. State 10b. County 10c. City, Town or Location	10d. Inside City Li
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	on of What Country?
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12. 0 Carpetrel 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Si	
Robert Garrett Nancy Ann Garrett	umemej
19a. Informant's Name/Relationship (Type, Print) Robert Garrett (Father) 19b. Mailing Address (Street and Number or Rural Route Number, City or 2 245 Hickory Ridge Drive, Queenstor	
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1 Burial 2 Cremation 3 Removed from State 4 Donation 5 Other (Specify) 4 Donation 5 Other (Specify) Commetery, Cremetery, Cremetery or other place) 2/17/00 Balt:	imore, Md.
21. Signature of Funeral Service Licenses 22. Nama end Address of Facility	
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3204 Mountain Road, Pasadena 23a. Part 1. Enter the disease, or complications that exceed the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.	, Md. 21122
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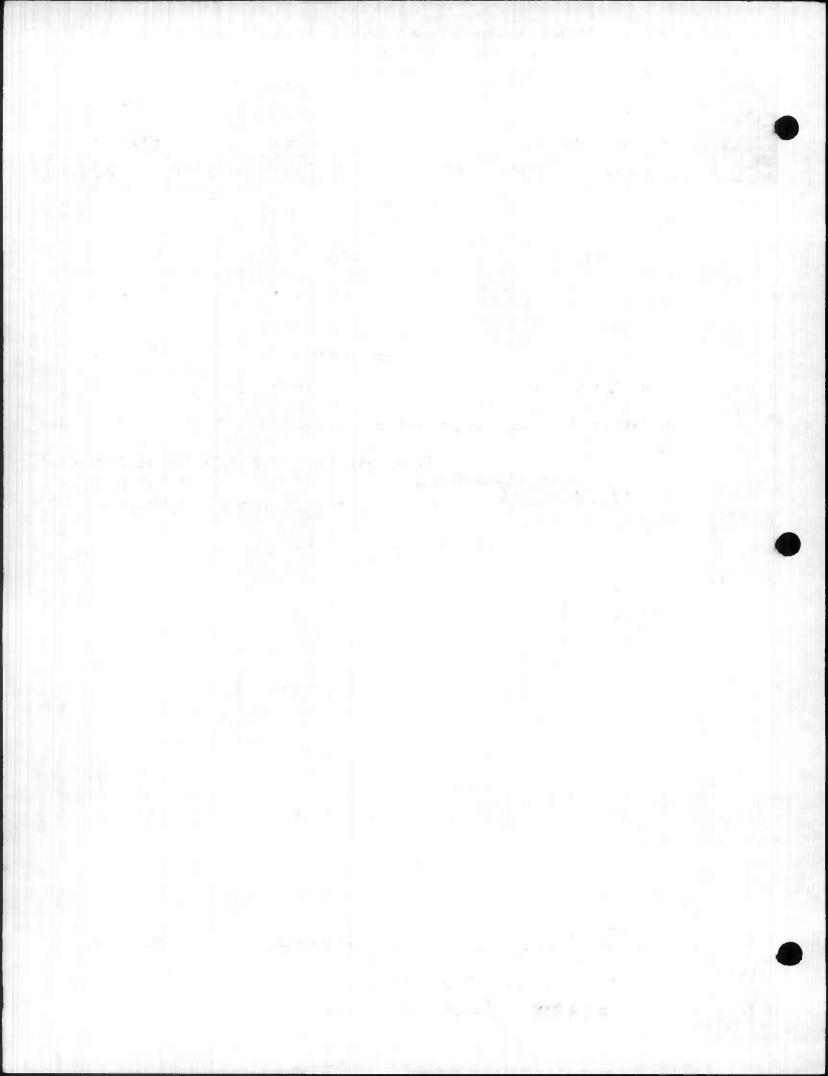
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 04814

					Certifica	ate of D	eath	R	eg. No.	040	1 -7
Dhua		1. Decedent's Name (First, Middle, L	ast)					2. Data of Deal Month	-	Year 3.	Tima of Death
Physi /Med		Beatrice B	. Hirt					02			0:25 am
Exam		4a. Facility Nama (If not institution, g	ive street and number)			4b.	. City, Town, or Lo	cation of Death	4c. County		
	.,.	Manor Care Ruxto	on				Towson		Ba:	ltimore	Co.
Funera Directo	_	5. Social Security Number 6. 212-03-4601 Usual Residence of Decedent	Sex 7. Ag 1 □ M 2 Ă F	87	Yrs. If Und Month		If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day 08/16/1	912	9. Birthplace Country) Balt	imore, MI
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after des	by Funeral Director	3X Widowed 4 ☐ Divorced	12. Was Decedant Armed Forces? 1 Yas 2 H If Yes, Give Year or Dates:	Ever in U,S.		cedent of Hisp pecify Cuban, 2 ¹ No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, atc.)	Biad	e - American inck, White, etc. White	dian,
n 72 hours a "natural", o	Completed	15. Decedent'a l	Education	16a	. Decedent's U	sual Occupati	lon		16b. Kind of Be	usiness/Industry	,
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12 sh and le m		19a. informant's Name/Relationship					nd Number or Run				
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		Michael		1/-	Lec	nard J	Ruck,	Inc.	Baltimo	ore, MD	
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or At	Ę	4 Homicide determined		ry - At home, to . <i>(Specify)</i>	irm, street, fact	ory, offica	(1)	28f. Location (Si City or Town		oer or Hufel Hou	te Number,
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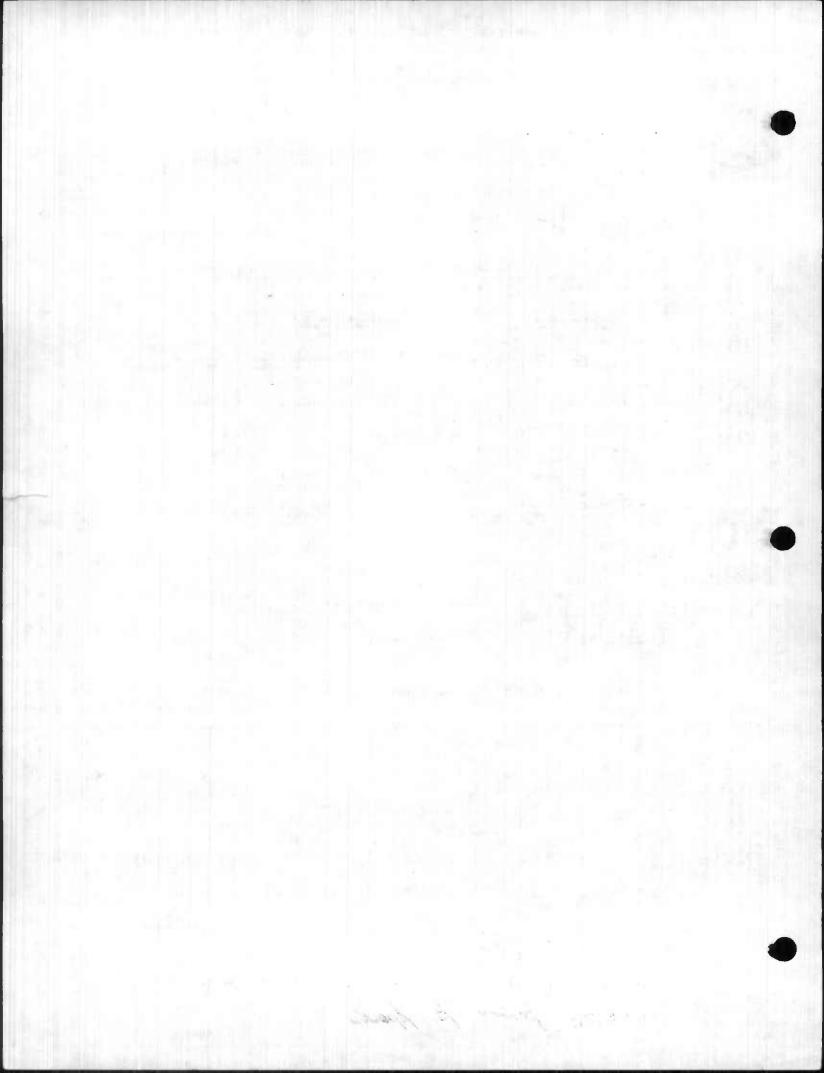
JACK M. TITUS, M.D.

31. Dete filed (Month, Day, Year)

FEB 1 6 2000

32. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201



Registrar

Physician

/Medical

Examiner

Funeral

Director

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altimore, Maryland 21215-0020

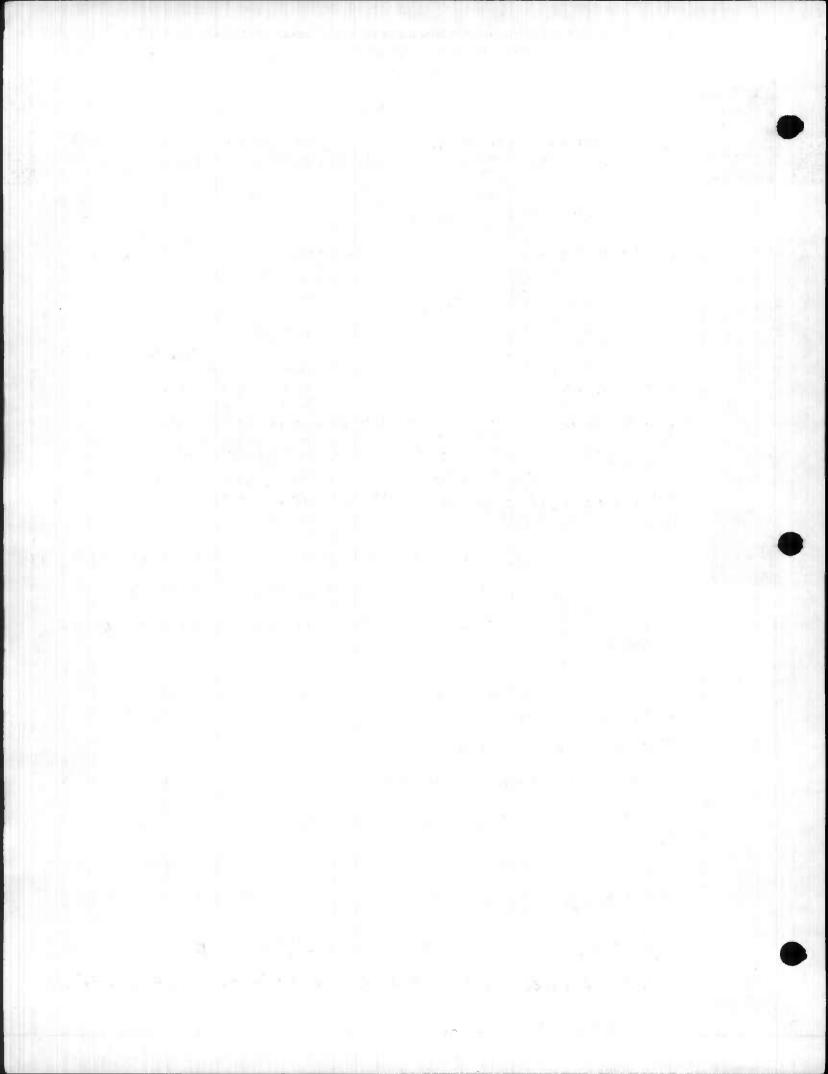
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the Maryland

death



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 0 04817 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Yaar Month **Physician** Albert Jerod Hammond February 09 2000 03:30 am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Aga (In yrs. last birthday) I Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) 5/22/1942 Birthplaca (State or Foraign Country) **Funeral** Days Hours XXM 2 F 57 Yrs 218-42-0041 Director Maryland Usual Rasidence of Decedent 72 hours after death with the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County Md. Anne Arundel Brooklyn Park 1 Tyas 2 TNO Director Hammond, Alber-Baltimore, Maryland 21215-0020 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? item 27 is marked other than "natural", or itema 23a or other traumatic event, the Modical Experience must be a 5704 Park Rd. U.S.A Funeral 12. Was Decedent Ever in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 21 No If Yas, Giva Yaar or Datas: 1 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Self Employed Bar- Tavern 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be 1 end 2 should be Health end Mental (not available) Frances Meekens 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addraas (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Mealth of Health Josephine Brown/sister 2729 Wilkens Ave. Baltimore Md. 20b. Placa of Disposition (Nama of camatary, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata ö Important: If it any injury or conce. Suriai 2 Cramation 3 Ramovai from Stata 2/14/00 Department 4 Donation 5 Other (Specify) Cedar Hill Cemetery Balto. Md. 22. Name and Address of Facility Gonce Funeral Home P.A. 21. Signature of Funaral Sarvice Licenses 4001 Ritchie Hwy. Balto as complications that caused the daeth. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, and cause on each line. 4001 Ritchie Hwy. Balto Md. Part1. Enter the disease, or shock, or heart failure. Ust Approximata Intarvai Batween Onsat and Daath Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) a Acute myocardial infarction days Examiner Due to (or as a consequence of): Examiner Coronary artery atherosclerosis vears physician and the burial-transit the death certificate be executed Sequantially list conditions, if any, laading to immediate causa. Enter Underlying Causa (Disease or injury that Initiated events rasulting in death) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of): 88 use. signed by the e Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown diabetes mellitus 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed hypertension complation of causa of death? page 2 has Yas 2 No 1 Yas 2 No certificate chronic renal failure or Attending Physician: 25. Was case rafarrad to medical axaminar? Be 26. Pleca of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) P 1 Yas 2 KNo ty⊡ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28b. Time of 28d. Dascribe how injury occurred 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 X Neturel 5 Pending invastigation 1 TYas 2 No 24 hours after death. 2 Accident 6 Could not be datarmined 3 ☐ Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida Hospital 29a. Certiflar Medical 😰 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and dua to tha cause(s) and mannar as stated To the Hosp within 24 ho To the Fune completaly fi (Check only one) 2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner steted. 29b. Signatura and titla of cartifier 29d. Data signed (Month, Day, Year) 29c. Licansa number February 10, 2000 30. Nama and addrass of person who completed causa of deeth (Item 23e) (Type, Print)

GBMC 6701 N. Charles St., Baltimore MD 21204

HW

State Registrar Rebecca A. Ludwig,

FEB 1 6 2000

31. Data filed (Month, Day, Yaar)

M.D.

2. Ragistrar's Signature

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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Funeral

Director

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Pages 1 and 2 should be lied within 72 hours after man of Health and Mental Hybjane.

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Baltimore, Maryland 21215-0020

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by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 8 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Dinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 No 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A72438946 FEBRUARY 14, 2000

State

Registrar

JONATHAN ROSEN FELD 31. Date filed (Month, Day, Year) FEB 1 6 200.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

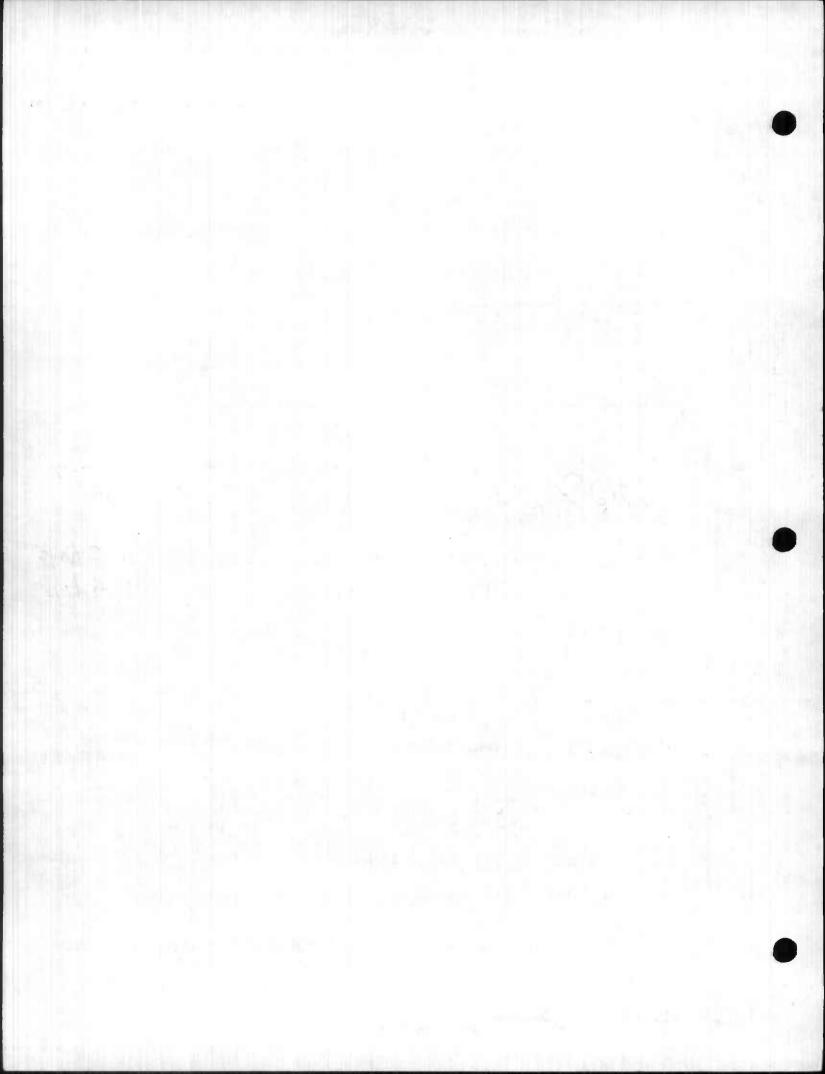
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00-0588-039 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. DDG State of Maryland / Department of Health and Mental Hygien JAMES M. JOYNES amend item 23a, 27, per me G780 2/17/00 yg Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JANUARY **Physician** 31, 2000 - AMES JOYNES 1320 PM MARion /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8874 FONTAINE ROAD MANOKIN SOMERSET If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 MM 2 F 45 Yrs. 217-30-954 Director 04-23-34 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No OMERSET MANOK:N Directo 288-1 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21836 8874 KD 1AING Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Black à 3 Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) STATE OF MARYLAND MAIntAinance 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Pages 1 and 2 should be nent of Health and Mental Jeorge Joynes Beulah Dolsey Mac 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health and it if item 27 is in or other traum DOISEY 21836 P.O. BOL 13 MD MAE Manokin SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stete Samuel Department of Important: If any injury or Cemedin 3-5-00 4 ☐ Donetion 5 ☐ Other (Specify) Wesley MANOKIA. 2. Name and Address of Facility
Anthony E. Ward Funcial
Diness 21. Signature of Funeral Service Licenses 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Plineess MO 21853 Approximate Interval Between Onset and Death **Physician** Immediata Cause (Finel disease or condition resulting in death) лиецісы ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or es a consequence of). Examiner sician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) physician s the buriel Box 68760. Physician/Medical Due to (or es e consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to should s 24a. Was an autopsy performed? Completed completion of cause of death? tooxYes 2 □ No 1XXYes 2□ No or Attending Physician: Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1⊠Xes 2□ No this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury st Work? 1 DiNeturai 5 Panding death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident after death 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) Vilhin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

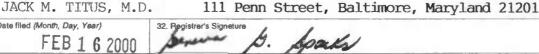
Registrar

DHMH 16 Rev 6/95

6 2000

31. Date filed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)



O.C.M.E.

FEBRUARY 1, 2000

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3. Time of Death

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21215-0020

altimore, Maryland

The law requires that the death certificate be executed P.O. Box 68760. the signed by Records. page 2 should certificate has Division of Vital this After

Physician /Medical Examiner Examiner or Attending Physician: after death. in by 24 hours a Hospital To the To the To the

Certificate of Death 2. Date of Death Year FIZBENARY 13, 2000 John E. Kerr 3.07 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RUSEUN ...
HUnder 24 Hrs. 8. Date of Birth (Month, Day, Year)
Tune 13 HOSPITAL CENTER FRANKLIN SOUARR ALTINOLE 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) 4 Maryland 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 216-01-9310 85 1914 Usual Residence of Decedent 10s State 10b. County 10c. City, Town or Location 10d. inside City Limits MD. Baltimore Parkville 1 ☐ Yes 2 No 10e. Street and Numbe 10f Zio Code 10g. Citizen of What Country? USA 8800 Walther Blvd. #4415 21234 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Pyes 2 No If Yes, Give WWII 1 Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Law Enforcement Police Lieutenant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rose Anna Stembler John Matthew Kerr 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. D. David Daily/ PR. 423 Chalfonte Dr. Catonsville, MD. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata cemetery, crematory or other place) 1 Removal from State Baltimore, MD. Mt. Olivet Cemetery 2-18-00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licental 22. Name and Address of Facility Towson Funeral Home, York Rd. Towson, MD. Ruck 1050 1nc. 21204 23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Finel · ACUTE MYOCARDIAU INFARCTION disease or condition resulting in death) UNKNOWN Due to (or as a consequence of): SEPSIS UNKNUWP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events regulting in death) Last Due to (or as e consequence of): NEUNONIA UNKNOWN Due to (or as a consequence of): Part II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 24a. Was an autopsy

Physician/Medical 1 Yas 21€No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 280 No 1 TYes 2 □ No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DEFVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNetural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000 FRANKLIN SQUARR DR BALTO, NO 2/237 BRUCK WATSON MD WILLIAM 31. Date filed (Month, Day, Year)

29c. License number

MD-D54594

29d. Date signed (Month, Day, Year)

State Registrar

FEB 1-6 2001

29b. Signature and title of certif

32. Registrar's Signature

the face of the same

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

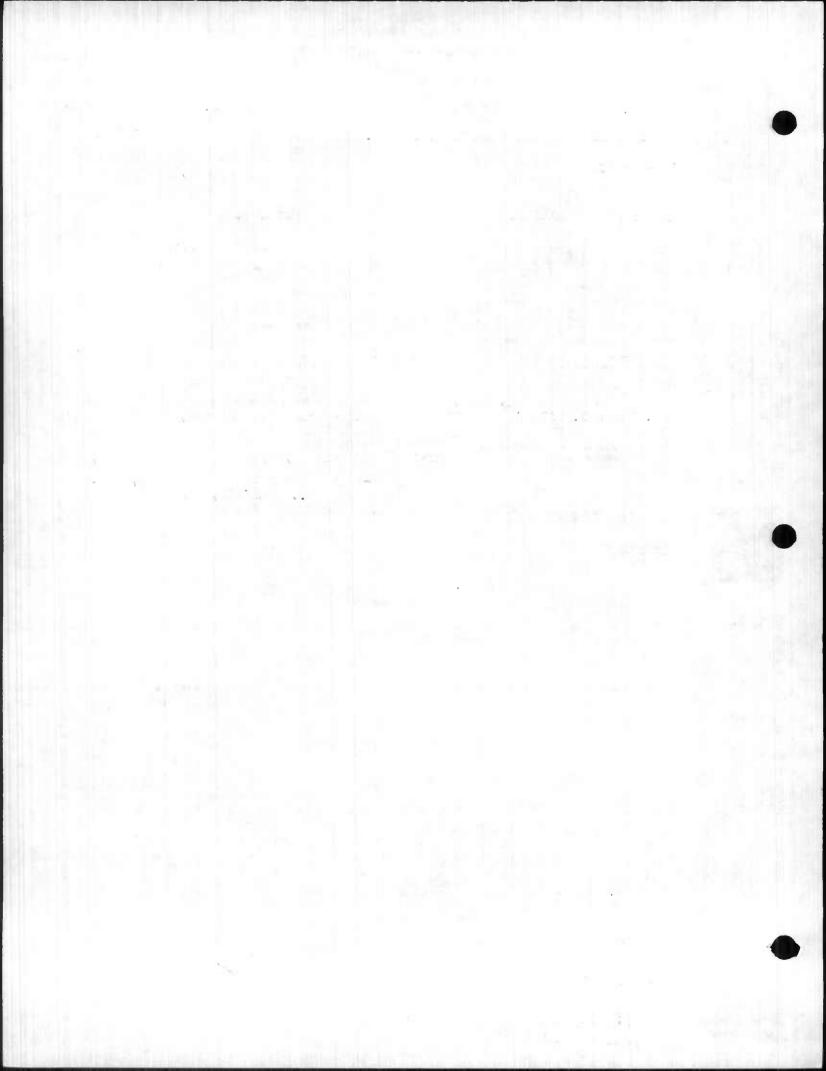
State of Manyland / Department of Health and Mental Hydierra

			State of F	viaiyiaiiu	Certifica		Death		Reg. No.	Art	821
	hysician	1. Decedent's Name (First, Mid						2. Date of De Month	ath Dev	Yeer	3. Time of Death
	/Medical	POENJAMIN	1 KRA					FEB.	10 2	000	1:00 PM
100	xaminer	4a Facility Neme (If not instituti			~		4b. City, Town, or La		,		
		Genesis Herita	-				Dundalk			ltimo	
	neral ector	5. Social Security Number 216-01-2134	6. Sex 1 → M 2 → F	Age (In yrs. last	Yrs. If Un Monti	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	th ly, Year) 6,1910		place (State or Foreign htry) ryland
P	3	Usual Residence of Decedent 10a. State 10b. Count	v	10c City T	Town or Location					1	Od. Inside City Limits
Manyle	art aho		Baltimore	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Fort Ho	ward			1 ☐ Yes 2 ☒ No
death with the Maryland	r tems 23s or 28s-f a liner must be notified Funeral Director	10e. Street and Number 9219 Todd Ave	enue		10f.	Zip Code	21052	?	10g. Citizen of S United S		
6 3	No than 'netural', or flams 23s or 28s-f ahow it, the Medical Examinat must be notified at Completed by Funeral Director	11. Marital Status 1 Never Married 2 Me 3 Widowed 4 Divorce	If Yes Give	S No	6.4		tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rad Ble Specif	ce - Americ ck, White, y:	
2 P	P P	15. Decede	nt's Education	1	6a. Decedent's U	sual Occup	nation during most of work	i	16b. Kind of B	usiness/înc	dustry
21; thin 7	old old	Elementary/Secondary (0-12)	est grade completed) College (1-4c	or 5+)	life. DO NO	Tuse retire	d) most of work	ing			
d 212	vent, trees	8 Years			Automobi]	e Ass	sembly		Genera	al Mo	tors
pu ag	9		, Last)				18. Mother's Name			ne)	
Vid b	To the	Ralph Kramer					Florer	ice Ette	er		
, Maryland and 2 should be file	mportant: if item 27 ta marked other than any Injury or other treumatic event, the the ance. To Be Comp	19a. Informant's Name/Relation Mrs. Karen I	ship <i>(Type, Print)</i> (Gr Daug Wilson	and)			and Number or Run venue For				21052
or He	E 6	20a. Method of Disposition			e of Disposition (f	Vame of	ce)	Date	20c. Location	City or To	wn, State
Pages Pages	= ŏ	1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (10	eland Ce			00	Chamber	sbur	a. PA
Baitimore, N permit. Pages 1 and Department of Health	eny Inju	21. Signature of Funeral Service			22. Name Duda-	and Addre	ss of Facility Funeral I	Home of	Dundal	c, Inc	c.
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Exam	physicien and street leading the burdel-transit street leading to the burdel-transit street leading to the burdel leading to the bur	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as	s a consequence of	of):	MONIA			1 2 5 4 11 10 10 10 10 10 10 10 10 10 10 10 10	
Geath certificate be executed	es the bur	Cause (Disease or Injury that initieted events resulting in death) Last	d	Due to (or as	a consequence of	of);					
1 0	d for	Part II. Other significant condit	lons contribution to death	but not resultin	og in the underlyin	a causa ni	ven in Part I	23b Did	tobacco usa co	entributa to	o the cause of death?
P. P.	detached for use		or in soling to doubt	Dut Not results	ig in the discerty.	y cause yn	COTTON COLLEGE		Yes 21 No		bably 4 Unknown
ords	page 2 should be detected by P							24a. Was	an autopsy mmed?	av.	ere autopsy tindings allable prior to impletion of cause death?
I Rec	Paga							10	Yas 2 No	1[Yes 2□ No
	rector, pag	25. Was case referred to medic	al				26. Place of Deat	h (Check only)	one)		
	I director,	examiner?	Hospital: 1 ☐ tope	itient 2□ER	/Outpatient 3□	DOA Oth			dence 6 □Ott	ner (Specif	(v)
		27. Manner of Death 1 Natural 5 Pend 2 Accident Inves	28a. Date of Ir	- 1	b. Time of Injury	28c. Injui			how injury occur		
- 555	ed in by the funer Certification:	3 Suicide 6 Couk 4 Homicide deter	mined 200. Place of	Injury - At home etc. (Specify)	, ferm, street, fec	tory, office		28f. Location (City or To	Street end Numi wn, State)	ber or Rura	al Route Number,
To the Hospital o	completely filled Medical Ce		ng Physician: To the besi Examiner: On the basis and manner	of examination							
ithin	Me M	29b. Signature and title of certific				29c. Licens	e number		29d. Date signe		
- 31	- 0	Cuupa	Lour M	D		1	6619		2/10	1/2	000
-	P	30. Name and address of person		7232	(Type, Print) GERM		HILL RD	BAG	T. MO	212	222
1000	State	31. Date filed (Month, Day, Year		strar's Signature	3	/					
R	egistrar	CER 1 G		and roman	B 10	park	2				

DHMH 16 Rev 6/95

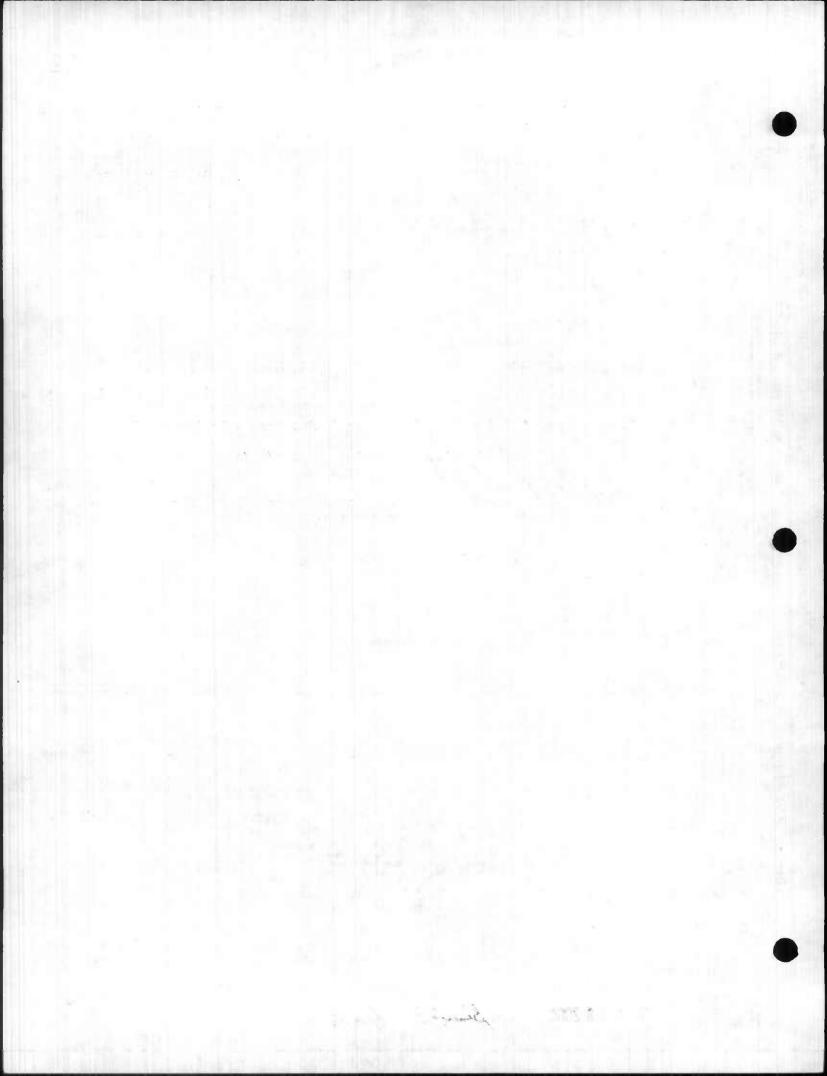
2004

ORIGINAL



						Cer	tificate c	of Death	R	eg. No.	04	822
	Physician		. Decedent's Nama (First, Middla, La	est)					2. Data of Deal Month	h Day	Year	3. Tima of Death
	/Medical		Helen Cata	nia Levy					Februar		2000	2:25 p.m
	Examiner		a Facility Nama (If not institution, given	va street and number)				4b. City, Town, or	Location of Death	4c. County	of Death	
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	Funeral	5	Social Security Number 8. 5	ITM STE		st birthday)	If Undar 1 Ya Months Da			Year)	9. Birthple Counti	aca (Stata or Foreigny)
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and the state of	or 28s-f	1	laryland Harfor	a	ва	ldwin	10f. Zip Cod	e	11	0g. Citizen of \	What Count	Λ
	23a or 28a-f sho ust be notified at		3103 Clearfield	d Court			210	1.2				
-	r Nama 23a Sinar mast	1	1. Marital Status	12. Was Decedent Ev	rar in U,S	. 13. V		of Hispanic Origin? (S Juban, Maxican, Puan	Specify Yas or No-		e - Amarica	
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arylan	Ment		John Catan:					Jennie		Paula		
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e, Me	Y Health and Mertal Hydrical Health and Mertal Hydrical Health and Mertal Hydrocal Character of the Traumatic event, I	_	erome J. Levy, S.	r. / Husban			Clearf:	ield Court				- 0111
0	= 6	12	0a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐	Removal from Stata	COL	matary, cram	atory or other	place)		20c. Location -		
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Baltimore,	Appa my fr mps	2	1. Signature of Funeral Service Lice	2/4/	1//	22.	Nama and Ad	drass of Facility		10	50 Yo	rk Road
-			14/00	1. post	7	Ru	ck Tows	son Funera	1 Home,	Inc. To	wson,	Md. 2120
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	/Medical xaminer	0	mmediata Causa (Final liseasa or condition esulting in death)	a. CEREBRO	OVASC	CULAR	ACCIDEN	T			1	
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Hospital	A Hille	2	9a. Certifier 1 Certifying Ph	ysician: To the best of	my knowl	ledge, death	occurred at the	tima, data and piace	and dua to the c	ausa(s) and ma	annar as sta	ated.
T.	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		(Check only 2 Medical Examone)	nysician: To the best of a niner: On the besis of a and manner state	xaminatio	on and/or inv	astigation, in m	y opinion, daath occu	irred at tha tima, d	ata and place,	and dua to	tha cause(s)
Tothe	THE DE LE		9b. Signatura and titla of certifier				29c. Lic	ense number	2	9d. Data signe		
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	1/1	3	D. Nama and addrass of person who	completed causa of das	ith (Item 2	23a) (Type. F						
	M//		DR. TARIQ MAHMO	OOD 2300 D	ULAN	EY VAL	LEY RD	. TIMONIU	M, MD 2	1093		
	State Registrar		1. Data filed (<i>Month, Day, Year</i>) FEB 1 6 200 0	37 Registrar	s Signatu	6.	Spark	2				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physiciar /Medica	DDOM:	LEVE	RING, J	R.		2. Date of De Month FEBRU	Day	2000	3. Time of Death 6:30 AM
*Examine	4a Facility Neme (If not institution, gi				4b. City, Town, or L			y of Death	
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Funeral Director		7714 OF F	B1 Yrs.	Months Days		8. Date of Bin (Month, Da 07-30-	7, Year) -1918		ace (Stete or Foreign ry) YLAND
with the Maryland a or 28a-f show Lbe notified at	10a. Stete 10b. County	'A	10c. City, Town or Lo		TY			10	Od. Inside City Limits
frer death with the Mar r frems 23s or 28s-f si viner must be nortified	10e. Street and Number 4413 UNDERWOO	DD ROAD		10f. Zip Code	21218		10g. Citizen of U.	Whet Count	ry?
O2(3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent E Armed Forces? XXYes 2 \(\subseteq \) If Yes, Give Year or Detes:		Wes Decedent of I If Yes, specity Cub 1 ☐ Yes XXNo	Hispenic Origin? (Speen, Mexican, Puerto Specify:	pecity Yes or No Rican, etc.)	Ble	ce - America ck, White, e	etc.
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Maryla d 2 should h and Mer T Is marke treumatic	19e. Informant's Name/Reletionship				t end Number or Ru				
E TO L	WILLIAM D. LEV 20e. Method of Disposition	ERING (SO	ON) 2205 20b. Place of Disp		DRIVE,	Dete	20c. Location		ND, 21209
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any hightry or otherway.	XX Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special	(h)	SATER'S	BAPT . C	H.CEM.	2-1₺			MD.,2109
Baltimoperant: Pag Department Important: Important: eny Injury o	21. Signature of Funeral Service Lice	W	4	905 YOR	. JENKII K ROAD,	BALTIM	ORE, MA		ND,21212
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. 57	TO K e						48h
			herosconse	dieuce oi):	i car	210 ve	isch	las	
60, be executed sician and burial-transit	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	0.	Due to (or es a conse	quence of):	i car		die	ase	
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Division Control of the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral Madical Certification.	3 Suicide 6 Could not l	De 00 00 11:	ry - At home, ferm, st (Specify)	reet, factory, office		28f. Location (City or To	Street and Num wn, Stete)	ber or Rura	l Route Number,
Divi	29a. Certifier XX Certifying P (Check only 2 Medical Exa	hyalcfan: To the best of miner: On the basis of and manner stat	examination end/or Ir						
To the within To the compl	29b. Signeture and title of certifier	Mylo	nner	29c. Licen	se number	9	29d. Date sign	10. 21	-6.00

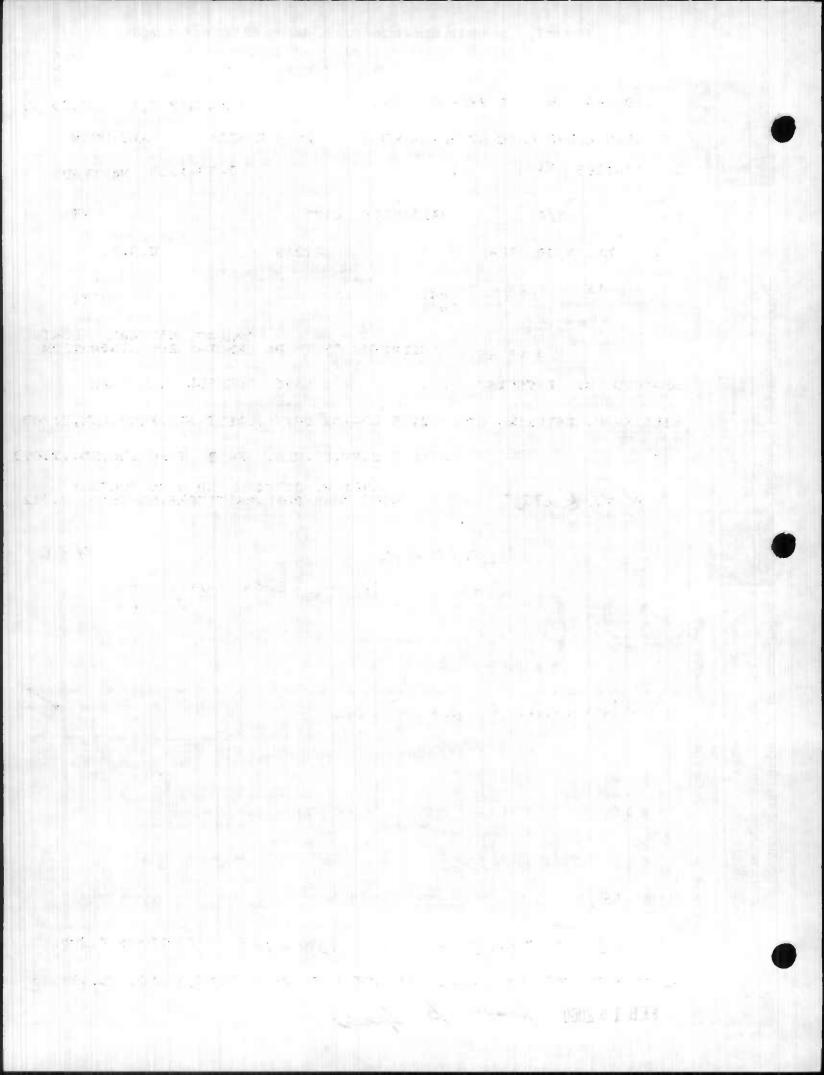
State Registrar 31. Date filed (Month, Dey, Year)

FEB 1 6 2000

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

WILLIAM D. McCONNELL, M.D., 500 WEST UNIVERSITY PKWY, BALTO., MD., 21218

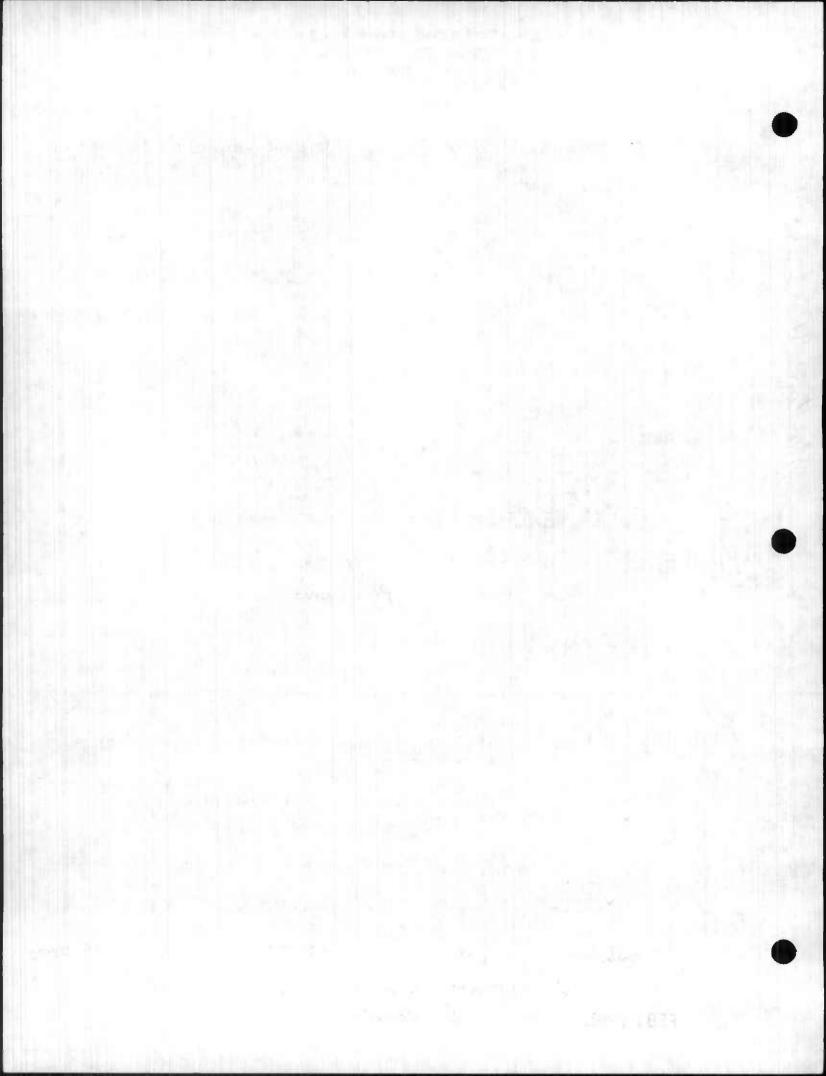
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 0 14824

									Reg. No.		
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ner	16 rth 5. Social Security		del	HOSP 7. Aga (In Irs.	tal	nder 1 Year		Location of Dea	e PINA	9. Birthplaca (Sta Country)	and e
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ctor	Maryland	Anne Art	undel		G.	len B	urnie			101	ras 2
Directo	10e. Street and N				10f,	Zip Coda			10g. Citizen of	What Country?	
	230 Roy	al Arms W	ay			210	61		USA		
by Funeral	3 ☐ Widowed	rried 2 Married 4 Divorced	12. Was Dece Armed For 1 XYes If Yas, Give Yaar or Da	2 □ No a			Hispanic Orlgin? (ban, Maxican, Pue Specify:	Specify Yea or N rto Rican, atc.)	o- 14. Rac Bla Specify	ce - American Indiar ck, Whita, atc. y: White	١,
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dev Year 1:55 AM James W. McCormack February 15, 2000 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Forest Haven Nursing Home Catonsville Baltimore County 8. Date of Birth (Month, Dey, Ye 8/20/1916 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 1 X X 2 □ F 83 Yrs. 705-05-8502 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes XIX No Baltimore Catonsville 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 701 Edmonson Avenua 21228 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 D Yes 2 □ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck. White, etc. 1 Never Merried 2 Merried 1 Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Conductor B & O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) James J. McCormack Sabina A. Ward 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Mahrenholz - sister 117 1st Avenue, W., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XX remetion 3 Removel from Stete 4 Donation 5 Other (Specify) Metro Crematory 2/16/00 Baltimore, MD 21. Signature Funeral Service License 22. Name and Address of Facility FINK FUNERAL HOME, PA kelly gregory Fink 426 Crain Hwy., SW, Glen Burnie, MD 21061 Enter the distantance complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Causa (Final NEUMONIA TON disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? /HROMBOSIS 1 Yea 2 No 3 Probably 4 Wiknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 € No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1. Natural 5 Pending investigation 1 TYes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stefe) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Examiner lician and burlei-transit The law requires that the death certificate be executed Box 68760. Physician/Medical the for use es signed by the e P.O. of Vital Records. Completed by certificata funeral director. Be Medical Certification: To this After Division or Attending

24 hours efter death. the 2 filled In Hospital completely

Physician

/Medical

Examiner

Funeral

Director

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Director

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Pages 1 and 2 should be nent of Health end Mentel

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Department of Important: If eny injury or once.

Physician /Medical

Examiner

21215-0020

Baitimore, Maryland

State Registrar

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31. Dete liled (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signeture and title of certifier

well

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated

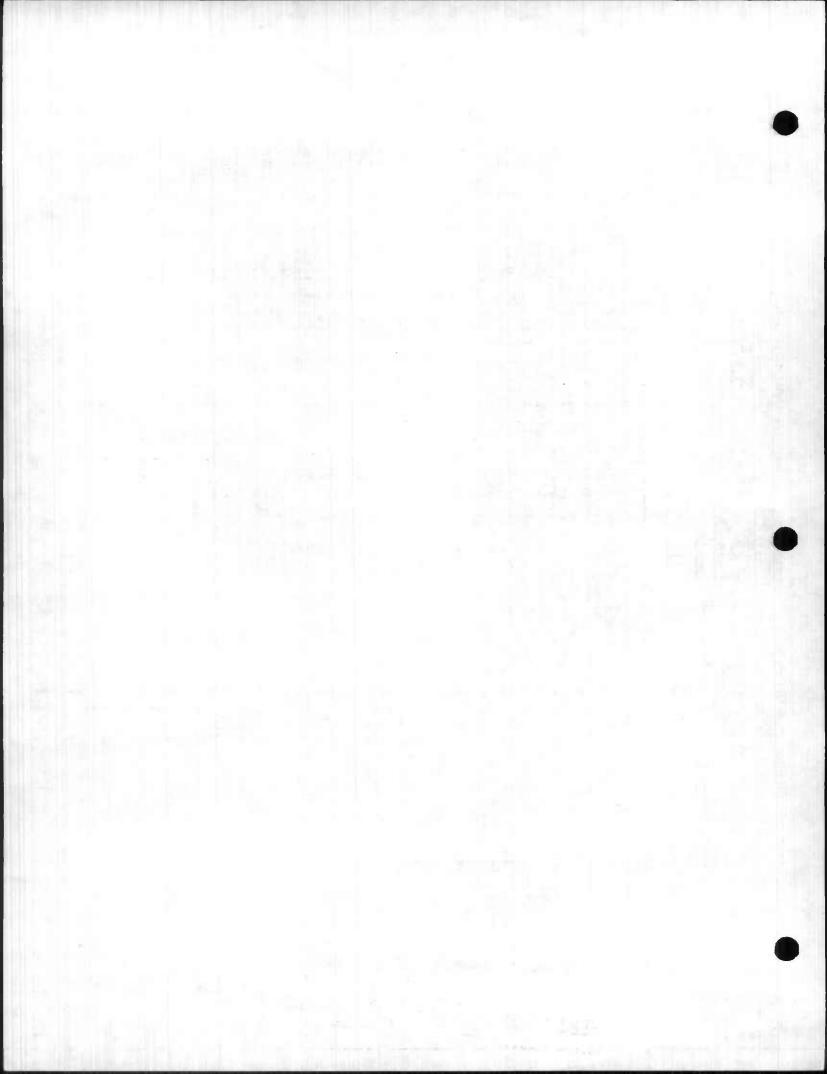
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Day, Year)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 1220 ASNEEM

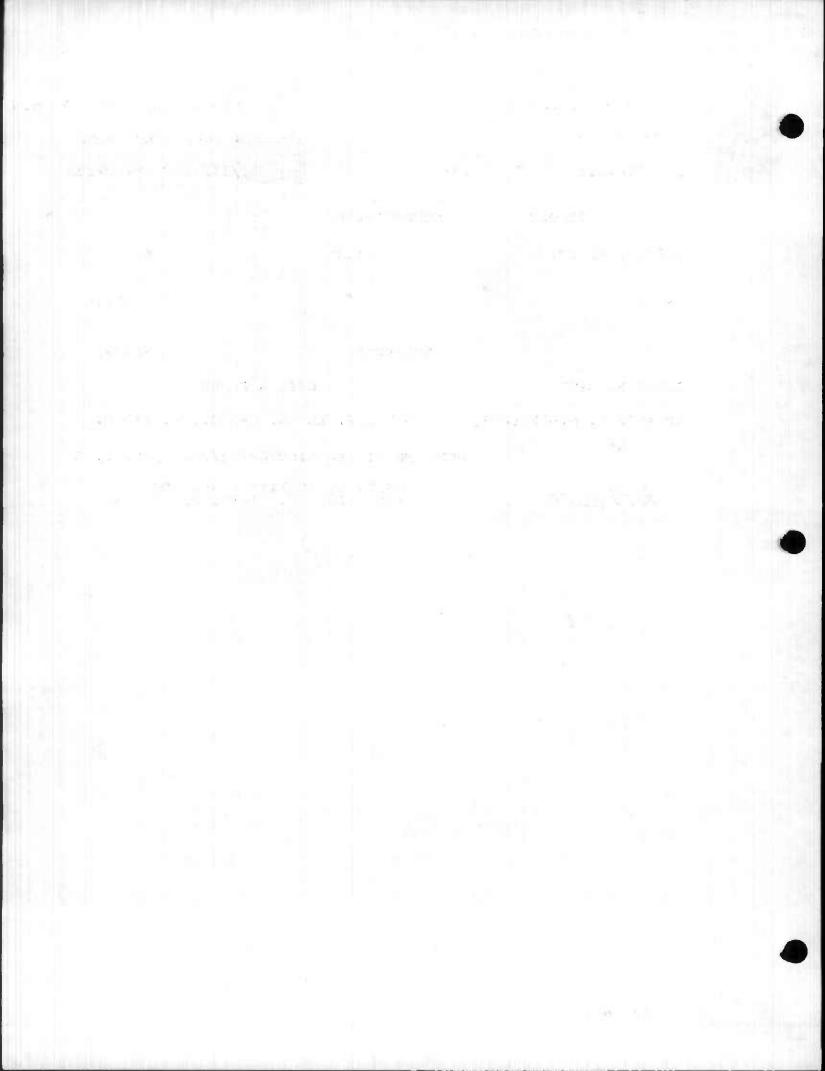
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	Physic /Medi		1. Decedent's Neme (First, Mic Katherin		ler				2. Date of De Month Febru		3. Tima of Death 2000 3:30 p.	
	Examii	ner	4a. Facility Name (If not instituted Broadnea		imber)				n, or Location of Deat Ckeysvil			
	Funerai Director		5. Social Security Number 212–28–7920	6. Sex 1 □ M 2 ■ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. 03/11/		9. Birthplaca (State or Foreign Country) NEBRASKA	
	Ba-f show	ctor	Usual Residence of Decedant 10a. State 10b. Cour MD BALT	IMORE		y, Town or Lo	CATION	6			10d. Inside City Limits 1 ☐ Yes 2 No	
	with the	i Dire	10e. Street and Number 13801 YORK	RD.			10f. Zip Code 21030	1		10g. Citizen of		
020	s 1 end 2 should be filed within 72 hours efter death with the Manyland I Heelth and Mentel Hyglene. If the marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be multined at	by Funeral Director	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	12. Was Dec Armed For arried 1 Yas	2. No	ver in U,S. 13. Was Decedent of Hisp If Yes, specify Cuban,			n? (Specify Yes or No Puerto Rican, atc.)	- 14. Ra	ca - Amarican Indian, ick, White, etc.	
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Mar	end 2 should selth and Men n 27 ie marke er traumatic		19a. Informant's Name/Relation DECATUR H.		ON)				or Rural Route Numb BALTO			
Baltimore,	Pege nent o int: If iry or		20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 4 ☐ Donation 5 ☐ Othar		Stata C8	ametary, cren	sition (Name of natory or other pla		Date RY02/15/2		- City or Town, State	
Balt	permit. Departn Imports any inju		21. Signature of Funeral Service	ce Licensae		H	ENRY W.	JENK	INS & SO	NS CO.	212	
	Physician /Medical personned by physician oud by physician oud set the physician out of the p	edicai Examiner	shock, or heart failure. Li Immediate Ceuse (Final disease or condition resulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Due to (or	r as a consequence as a	uence of):	IA			Infarval Between Onset and Death	
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-	e Hospital	edicai C	29e. Certifier (Check only one)	ring Physician: To the al Examinar: On the b and man	bast of my know asis of examinati nar stated.	viedge, death ion and/or inv	occurred at the tirestigation, in my o	me, dete end p pinion, deeth	place, and due to the occurred et the time,	cause(s) and m dete and place,	anner as stated. and due to the cause(s)	
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	Sta Registr		BARBARA 31. Date filed (Month, Day, Yea FEB 1 6 20	CARA	ROLL legistrar's Signatur	M.L	138	01	YORK	RD.y	COCKEYSVILLE	



Examiner

Physician

/Medical

Examiner

Funeral

Director

the Medical Examiner must be notified

filed within

Maryland

permit. Pages 1 and 2 should be tiles. Department of Health and Mertal Hrg Important. If them 27 is marked other any injury or other traumatic event,

Physician /Medical

physician and the burial-transit

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Examiner

Physician/Medical

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Certification:

Medical

29a. Certifier (Check only one)

Box 68760 P.O. Records, Division of Vital i or Attending Platfer death.

Director: After the in 24 hou.
The Funeral Directory the fulled in by the Hospital To the Hosp within 24 ho To the Fune completely fi

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year) FEB 1 6 2000

29b. Signature and title of certifier

C. Brown, MD 32. Registrar's Signature Genera

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0004

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Sinai Hospital of Baltimole ooks

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

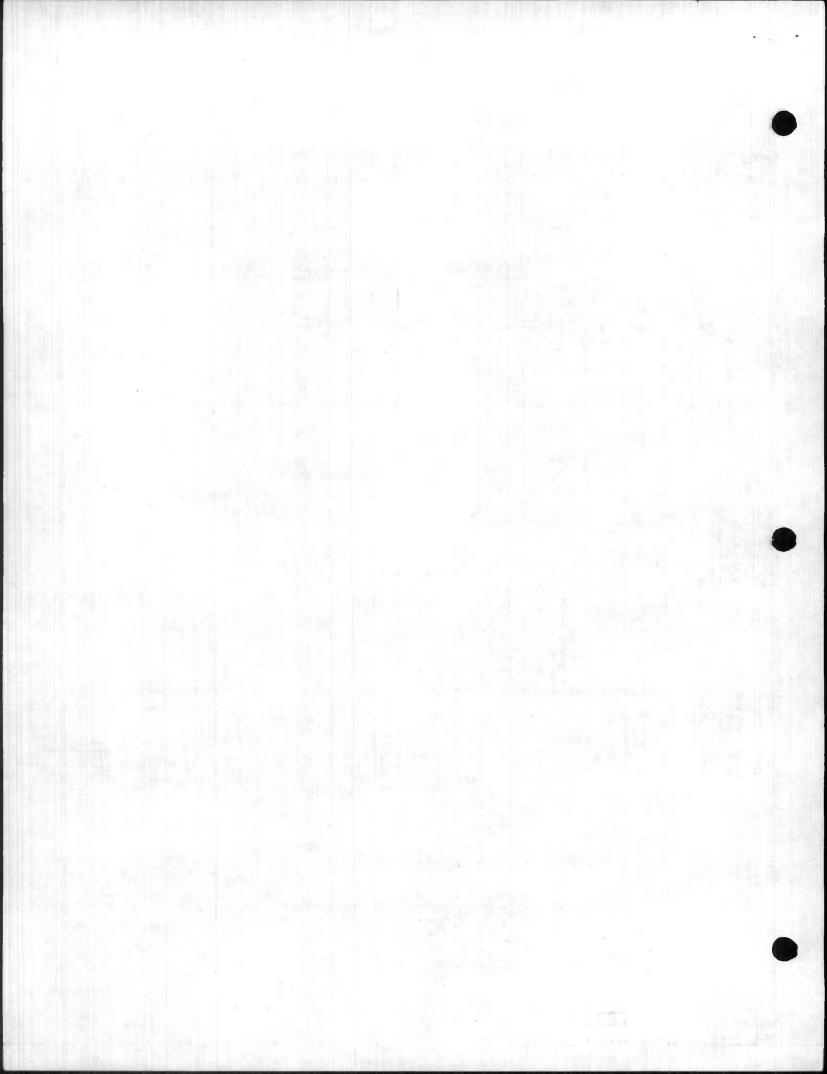
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

285-000

29d. Date signed (Month, Day, Year)

February 11, 2000



Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 4 8 2 8

		Certificate of Death	Reg. No.	04020									
Physician	1. Decedent's Name (First, Middle, Last) Frank H. Mattes		2. Date of Death Month 02-06-2000	Year 9:30 pm									
/Medical Examiner	4a Facility Name (If not Institution, give street and number) Manor Care	4b. City, Town, or Baltimore	· · · · · · · · · · · · · · · · · · ·	ol Death									
Funeral Director	215-05-0632 X /Z	hday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 02–14–1917	Birthplaca (State or Foreign Country) MD									
ith the Maryland or 28a-f show as notified at Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Baltimore Baltimore			10d. Inside City Limits 1√2 Yes 2 □ No									
2 44 64	10e. Street and Number 2400 Hudson Street	10f. Zip Code 21224	10g. Citizen of What Country? USA										
her day her day net m	11. Marital Status 1 Never Married 21 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl □ Yes 2 No Specify:	pecify Yes or No- lo Rican, etc.) 14. Race Blac Specify	e - American Indian, k, White, etc. White									
Maryland 21215-0020 of 2 should be lited within 72 hours at the and Merchal Hygiene. This marked other than "natural", or traumetic event, the Medical Example TO Be Completed by F	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) eavy Equipment Opera 18. Mother's Nei Mary Held	ator City of me (First, Middle, Maiden Sumam										
	19a. Informant's Name/Relationship (Type, Print) Mrs. Marie Mattes-Wife 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2400 Hudson St., Baltimore, MD 21224												
Baltimore, M semit. Pages 1 and oppurment of Health mportant: if Hem 27, my Injury or other tr	20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of camping, cremetory or other placa) St. Stanislaus Cem. 20c. Location - City or Town, State 2-10-2000 Baltimore, MD												
Baltin pemit. Pa Departmen important any injury once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Homes, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222												
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) List only one ceuse on each line. Coronar Due to (or es a condition resulting in death)	y Artery Dis		Approximate Interval Between Onset and Death									
BOX 65/60, seth certificate be executed thending physician and for use as the burial-transit claryMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a death)												
. 0 00	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Pert I.	23b. Did tobacco use cor	3 Probably 4 Utikno									
w requires t s been signe 2 should be			24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?									
of Vital Records, Physician: The law requires the this certificate has been signeral director, page 2 should be cral director, page 2 should be cral for the completed by the complete complet	25. Was case referred to medical examiner? Hospital:	Other:	1 ☐ Yes 2 💢 No ath (Check only one)	1 □ Yes 2 No									
Division of Vital Records, P.O or Attending Physician: The law requires that the after death. Director: Attenthis certificate has been signed by the in by the funeral director, page 2 should be detached in by the funeral director. Page 2 should be detached in by the funeral director.	27. Manner of Death 1 Matural 5 Pending investigation 2 Accident Population 2 Could not be	ime of hjury M 1 Yes 2 No	tome 5 ☐ Residence 8 ☐ Oth 28d. Describe how injury occurr	ed									
Division C Per Hospital or Attending PI n 24 hours after death. Ne Funeral Director: Attent pletaly filled in by the funera edical Certification:	4 Homicide determined 256. Place of injury - At nome, tale building, etc. (Specify)	28f. Location (Street and Numb City or Town, State)											
Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Attendonpletally filled in by the funeral Medical Certification	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated. 29b. Signature and title of certifier	d/or Investigation, in my opinion, death occi	urred at the time, date and placa,	and due to the cause(s) d (Month, Day, Year)									
	30. Name and address of person who completed cause of death (ftem 23a)	D 4372 5		6/00									
State	TARIQ MA (Amoul) 201-109 B 31. Date filed (Month, Day, Year) 32. Registrer's Signature	Type, Print) ack River Neck B. Sports	Road Balhin	ore MD 21221									
Registrar	FEB 1 6 2000 Deniva	B. Sports											

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Dey Month FEBRUARY 11,2000 7:45PM Katherine J. McConnell 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs. If Under 1 Year Birthplece (State or Foreign Country)
 MD. 5. Social Security Number 8. Deta of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours 1□ M 2Q F January 10, 1944 216-42-4244 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 3 Kilglass Court Apt. 104 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, Whita, atc. 1 Never Married 2 Merried 1 Yes 2 No 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Secretary 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha L. Dunivant Raymond C. Nelson 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Timonium, MD. 21093 9 Heuetson Court Donald McConnell (former husband) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) 2/16/2000 Towson, MD. Hilltop Service Corp. 21. Severe of Funeral Service Ligensee Dennis C. Caproll 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 1050 York Rd. Towson, MD. 23a. Part Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest Approximate Intervel Batween Onset and Deeth Immediate Cause (Final SEPSIS disease or condition resulting in death) Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 Accident 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending 1 Tyes 2 No investigation 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

Box 68760 P.O. Records. Division of Vital Attending death. To the Hospital or Attendis within 24 hours efter death.
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Pages 1 and 2 should

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State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of og

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SHEND 32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

F.B. M.C.

29c. License number

29d. Date signed (Month, Day, Year)

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Division

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State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Diev **Physician** JEAN ETTE
4e Facility Name (If not institution, give street and number) c. County of Death 25 /Medical 4b. City. Town, or Location of Death Examiner Lew 5. Social Security Number mare! notro unne Mun DEL If Under 1 Ve If Under 24 Hrs. 8. Dete of Birth (Month, Day, Birthplace (State or Foreign Country) yrs. last birthday) **Funeral** Months Days Hours 1 □ M 200 F 67 Vrs 218-28-9937 Director Sep.4,1932 Carolina N. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location - how 10d. inside City Limits Md. Director Anne Arundel Baltimore 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23s or 8600 Main ave. 21122 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11 Merital Stetus 72 hours after 1 ☐ Yes **X**XNo If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried natural, or Specify: White 1 ☐ Yes 2 ☑ No Specify: p 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Cashier/Clerk Pantry Pride 12th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 8 and Mental 1 and 2 should Hazel M. Bryant Clarence M. Prince 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Health a Michael Munchel/son 2017 Heritage Drive Balto., Md. 21209 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Pages 5 Important: If It any Injury or once. XOBurial 2 Cremetion 3 Removel from Stete Department 4 ☐ Donation 5 ☐ Other (Specify) 2/15/00 Vets. Cemetery Crownsville, Md. 21. Signeture of Funeral Service Licensee 22. Neme end Address of Facility Gonce Funeral Home P.A. Baltimore Md. 4001 Ritchie Hwy. 21225 20a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or healf feilure. List only one cause on each line. Approximate Intervat Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Couse (Disease or Injury that initieted events resulting in deeth) Last use as the burial-tran Due to (or es a consequence of): PREMODER Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Medical Certification: To Be Completed 1 Yes 1 Yes No 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: 1□ Yes 201No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA After this Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28d. Describe how injury occurred 1 Naturel 2 Accident To the Hospital or Attending 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 3 Suicide 28e. Pleca of injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) leve leve 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State FEB 1.6 2000 Registrar

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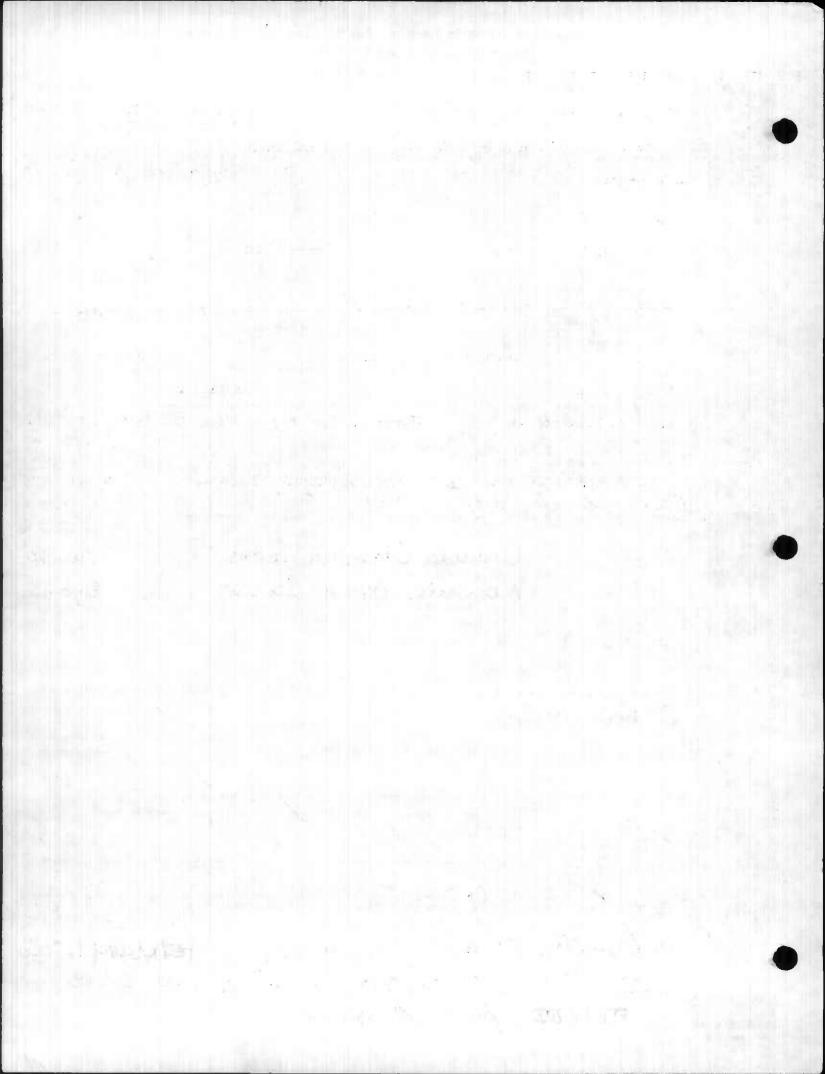
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	19a. informent's Neme/Relationship (Type, I	Print)	19b. Mailing Address (Street			City or Town,	State, Zip						
	Donald E. Mummert/so	on	817 1817 St. I	Paul Street	# 410	Baltim	ore,	MD 21202					
	20a. Method of Disposition 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Remo		laca of Disposition (Name of emetery, crematory or other p	place)	Date 2	Oc. Location -	City or Tov	wn, State					
	4 Donation 5 ☐ Other (Specify)												
	21. Signature of Jungal Sprice ican van Sant State and Address by a Board 655 W. BaltimoreStreet												
•	Baltimore, MD 21201												
	23a. Per Enter the disease, or complication shock, or heart failure. List only one can	ons thet caused the death	n. Do not enter the mode of o	lying, such as cardiac	or respiratory erre	st,		Approximate Interval Between					
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TIE	3 ☐ Sulcide 6 ☐ Could not be determined 2	8e. Placa of Injury - At he building, etc. (Specifical Control of the Control	ome, farm, street, factory, office	De .	28f. Location (Sti City or Town		er or Rurai	Route Number,					
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edical Certification:	29a. Certifier (Check only one) 1 Certifying Phyelcla 2 Medical Examiner:	n: To the best of my kno On the basis of examina and manner stated	wledge, deeth occurred at the tion end/or Investigation, In m	time, date and plece, y opinion, deeth occur	and due to the ce red at the time, de	use(s) and ma ite and place, a	nner as stand due to	ated. the cause(s)					
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	30. Name and address of person who comple	eted cause of death (Item	(Type, Print)	2 - 11 -		w.	715	18					
	30. Name and address of potent who completed 33.33 N. Call V. Call V. G. 31. Date filed (Month, Day, Year)	eted cause of death (Item	Ste 575, 1	Baltin	ore, N	D.	212	18					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Herman Nelson 02 2 2000 9:15pm /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Augsburg Lutheran N/H Baltimore If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1⊠M 2□F Months Yrs 241-14-3066 78 05 26 21 S.C. Usual Residence of Decedant 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2918 Ulman Ave Funeral 21215 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② Mo If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Status 14. Reca - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes XIXNo Specify: by Specify: 3 Vidowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 10th grade 17. Father's Name (First, Middla, Last) Sparrows Point Longshoreman 18. Mother's Name (First, Middle, Maiden Sumeme) Napoleon Nelson Annie James Nelson 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stete, Zlp Code) Terry N. Patterson-Sister 4715 Keppler Place, Temple Hill, Md 20748 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn Cemetery 2-17-00 Baltimore Co, Md 21. Signature of Funerel Service Licansee 22. Neme end Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part Effect tha disease, or complicate 43 that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feliure. List only one cause on each line. Approximete Interval Between Onset end Death Immediata Causa (Final Metastatic disease or condition resulting in death) Diostate 400 Due to (or as a consequanca of): Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that Initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequenca of): Part II. Other significent conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 48 Unknown 1 Yes 2 No 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 212 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Pieca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending investigation 1 Waturai 1 Yes 2 No 2 Accident 6 Could not ba determinad 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 I Homicide 29a. Certifier tell Certifying Physician: To the best of my knowledge, daath occurred et tha tima, date and place, end due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one)

The law requires that the death certificete be executed P.O. Box 68760, Division of Vital Records, Attanding Physician: To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi

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Baltimore, Maryland 21215-0020

State Registrar

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29b. Signeture and title of cartifier



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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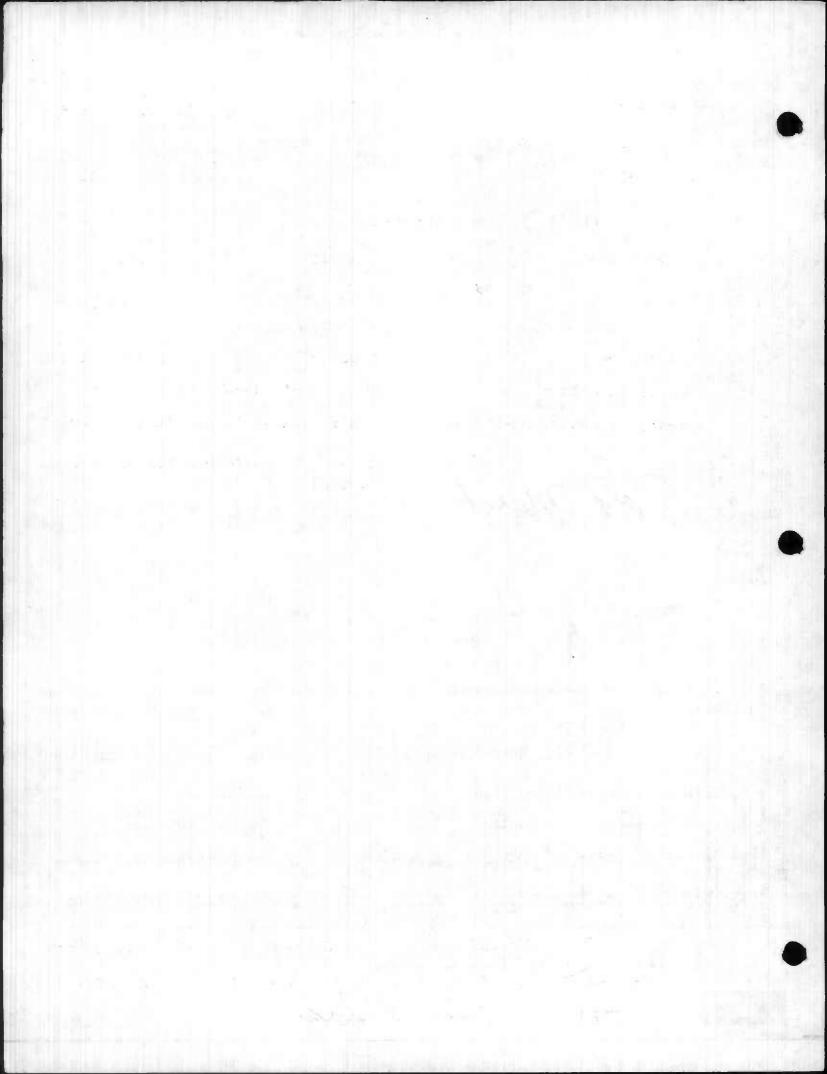
29c. License number

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29d. Date signed (Month, Dey, Year)

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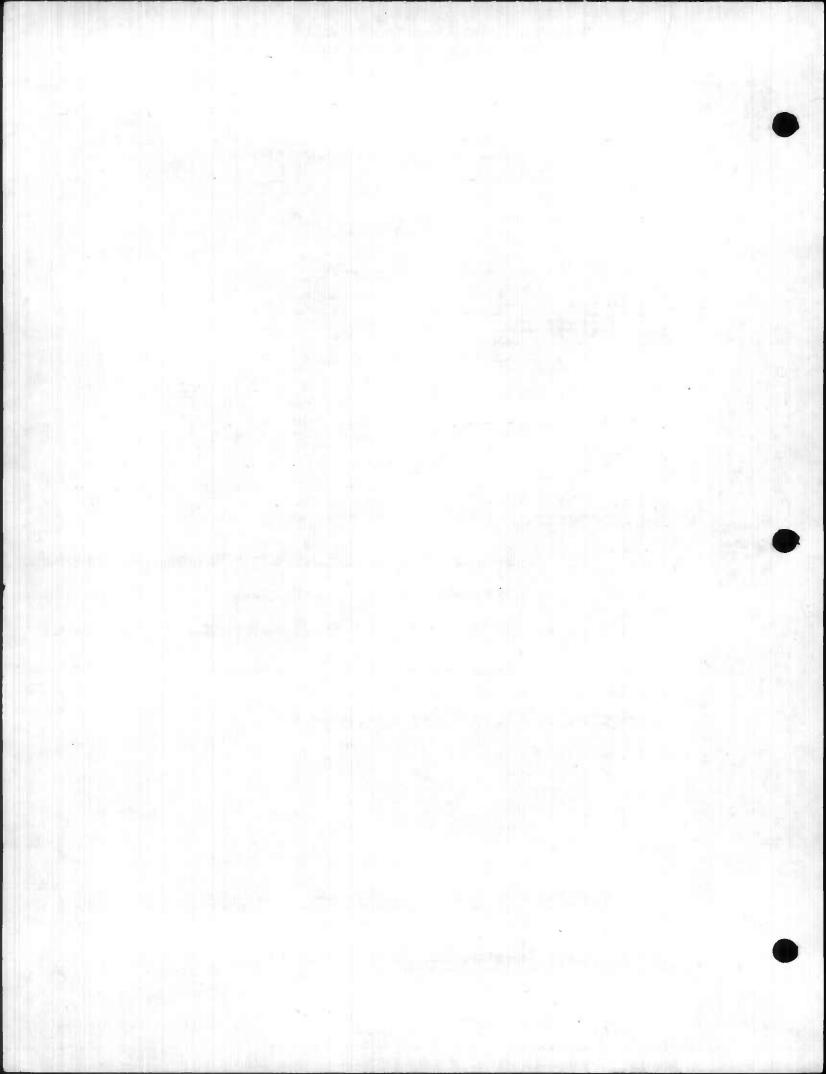
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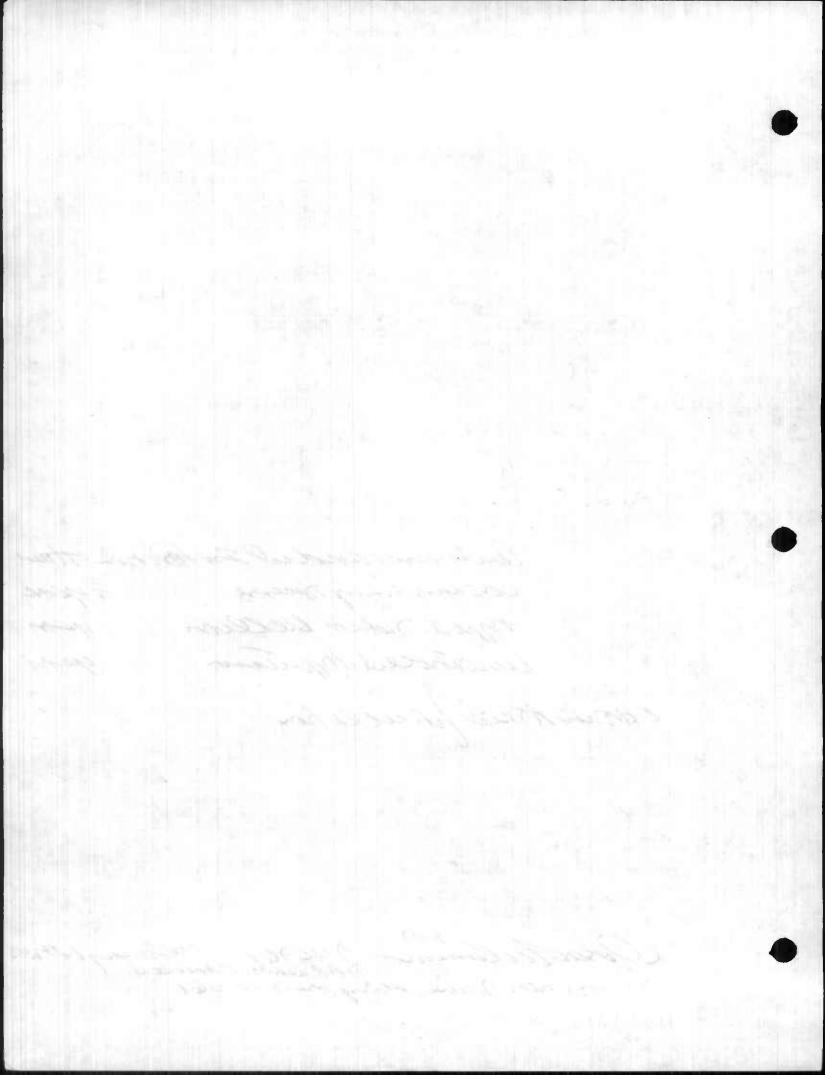
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	uneral rector	5. Social Security Number 6. Se 15 214-09-8582 Usual Residence of Decedent	XM 2□ F 83	yrs. last birtho	Months Days		8. Data of Birth (Month, Day, Oct. 26		Birthplaca (Stata or Foreign Country) Ohio		
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Ital	certificate rector, pag	25. Was case refarred to medical				26. Place of Dea	th (Check only one				
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C 2	her th	27. Manner of Death 1t Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Ye	28b. Tim tnju	ry W		28d. Dascribe hov				
Divis	el Director: Afferti led in by the funera Certification:	3 Suicide 6 Could not be detarmined	28e. Place of Injury - building, etc. (S	At home, farm pecify)	, street, factory, office	9	28t. Location (Str. City or Town,	eet and Number Stata)	or Rural Route Number,		
DIVISIO To the Hospital or Attendit within 24 hours after death.	pletely fille		nician: To the best of my ner: On the basis of axa and manner stated.								
Toth	comit	29b. Signatura and titla of certifier	(4 And)	M -	0 7	15a number 4827	0	2 - 10	Month, Day, Year)		
	0	30. Nama and address of person who co	mpleted cause of death Koulf	(Item 23a) (Ty	po. Print) Osle	2 D/10	4 SW	Te 223	Towson, MI		
,	State	31. Data tiled (Month, Day, Year)	32. Registrar's S	Signatura	h la	w Was					
F	Registrar	EED 1 6 2	non Sem	and !	13 100	w					



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State of Maryland / Department of Health and Mental Hygiene 1 14 8 3 4

Dhusisis	1. Decedent'a Nan	ne (First, Middle	, Last)			tificate c			2. Date of De Month	ath Day	Yaar 3.	Time of Death	
Physician /Medical	_Anna ^	Mary F	atterson		_				Februar		2000 9	:50 AM	
Examiner			, give street and num	nber)					cation of Death				
	7733 West Drive				W Hodor & Vo		Burn			Arundel			
uneral rector	5. Social Security i 212-18-(Usual Residence of	0831	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs.	78 Yrs.	If Under 1 Ya			8. Date of Bird (Month, Da July 2	0 1921	9. Birthplaca Country) Mary lar	(Stata or Foraig	
show ed.at	10a. Stata 10b. County 10c. City, Town or Location										10d. lr	side City Limits	
illad tor	Maryland	Anne A	Arundel	Gle	n Burni	е					1	□Yas 2X□No	
at be notified	7733 Wes		9			10f. Zip Cod 2	1060			10g. Citizen of US			
Examiner must	11. Marital Status 1 □ Never Mar 3 □ Widowed	ried 2 Marri	12. Was Dece Armed For 1 Yas If Yes, Giv Yeer or Da	ces? 2 D(No		Vas Decedent (Yes, specify C			city Yas or No Rican, etc.)	Bla	ce - American Inck, Whita, etc. by: White	dian,	
rt, the Medical	(Spe		's Education t grade completed) College (1	-4or 5+)	(Give	ent's Usual Ockind of work do	na duning m (ired)	ost of worki	ng		usiness/Industry		
	17. Fathar's Name	(First, Middle, I	Last)				18. Mo	ther's Neme	(First, Middle.	Maiden Sumer	ne)		
ic ever		Bisesi							Marie				
r traumat	19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 418 Samantha Court, Glydon, MD. 21071											Θ)	
ny or othe			3 □Removal from S			sition (Name of netory or other idge Ce							
any inju	22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122 23a. Part I. Enter the Nease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between												
physician and the burial-transit the burial-transit	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or thet initiated event	onditions, mmadiate erlying rinjury	b. Co	pres	or as a conseq	offer	Be L	uel	lep	9	7	yan	
98 9	resulting in death)	Last	a Class	LONA	ras a consequence		type	ula	in		9	plops	
igned by the attendin be detached for use by Physician/N	Part II. Other signi	ficant condition	ns contributing to de	ath but not res	ulting in the un				23b. Dld	tobacco use co	ontribute to the	cause of death	
should should				0					24a. Was	. Was an autopsy performed?		utopsy findings le prior to tion ot causa n?	
certificate has rector, page 2 Be Comp									10	Yes 2 No		s 20 No	
ctor. p	25. Wes cese rete examiner?	rred to medicel					26. Pl	ace of Death	(Check only	one)			
Joseph J	1 Yes 2	No			ER/Outpatien	3□ DOA	Other: 4	Nursing Ho	me 52 Resi	dence 6 🗆 Ott	her (Specify)		
After	27. Manner ot Dea 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicida	th 5 Pending investig 6 Could n determi	ation ot be 28e. Place	t Injury h, Day Year) of Injury - At h g, etc. (Specif	28b. Tima of tnjury ome, farm, stri y)		njury at Work? 1 ☐ Yes 2	□No		Street and Numi	ber or Rural Rou	ute Number,	
by filled cal Ce	29e. Certifier (Check only one)		Physician: To the lexaminer: On the ba	sis of examina									
T 8 10	Orre)		and main										
To the Funeral Director: completely filled in by the	29b. Signature and	title of certifiar	Mes	land	Pad cun-	29c. Lic	ense numbe	76		39d. Data signed	ed (Month, Day,	(US)	



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vesi **Physician** 15:03 2000 Slobodan Petrovich FEBRUARY 11 /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE HEALTHCARE AGNES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months NOW 20 F Director Aug. 21, 1939 329-36-5661 60 Yugoslavia Usual Residence of Decedent deeth with the Meryland 10a. Stale - Phow 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 25s-f shorted at the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Sharenwood United States 21228 11. Merital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. Wes Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours effer or and of Health and Mentel Hygiene.
It it item 27 is marked other than "netural", or item iny or other traumatics event, me tended. 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Profesor Education 17. Father's Nema (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Borislav Petrovich Milena Milenkovic 19s. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6517 N. Caldwell Chicago, II. 60646 of Disposition (Name of Date 20c. Location-Svetozar Petroyich (Brother) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel Irom State permit. Pege Depertment of Important: If eny injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) St. Sava 2/17/00 Libertyville, Il. 21. Someture of Funeral Service Licente 22. Name and Address of Fecility Ambrose Funeral Home, Inc. 1328 SUlphur Spring Road Arbutus, MD 23a. Part I. Enter the disease, or complications that deused the deute.

Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leiture. List only one cause on each line. Approximete Intarval Between Onset and Death Physician tmmediate Causa (Final disease or condition resulting in death) /Medical CARDIOGENIC FIVE HOURS Examiner Due to (or as a consequence of): Examiner physician and s the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): NAME PETROVICIT SCCBODAN EDIVISION of VItal Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 8 997 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 22 No 3 Probably 4 Unknown à page 2 should to 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 ☐ Yes 2 No 1 Yas 2 No After this certificate Physician: Be 25. Was case refarred to medical 26. Place of Death (Check only one) ToT Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At homa, larm, street, factory, office building, etc. (Specify) filled in by Hospital or A 24 hours effer 4 | Homicide 24 hours 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. within 24 hor To the Fune completely f (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier P13604 MEDICAL RESIDENT FEBRUARY 11 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print) CATON AVENUE BALTIMORE MD 2/229 ICHARD 900 OFFEL ADDO 31. Date liled (Month, Day, Year) 32. Registrer's Signature

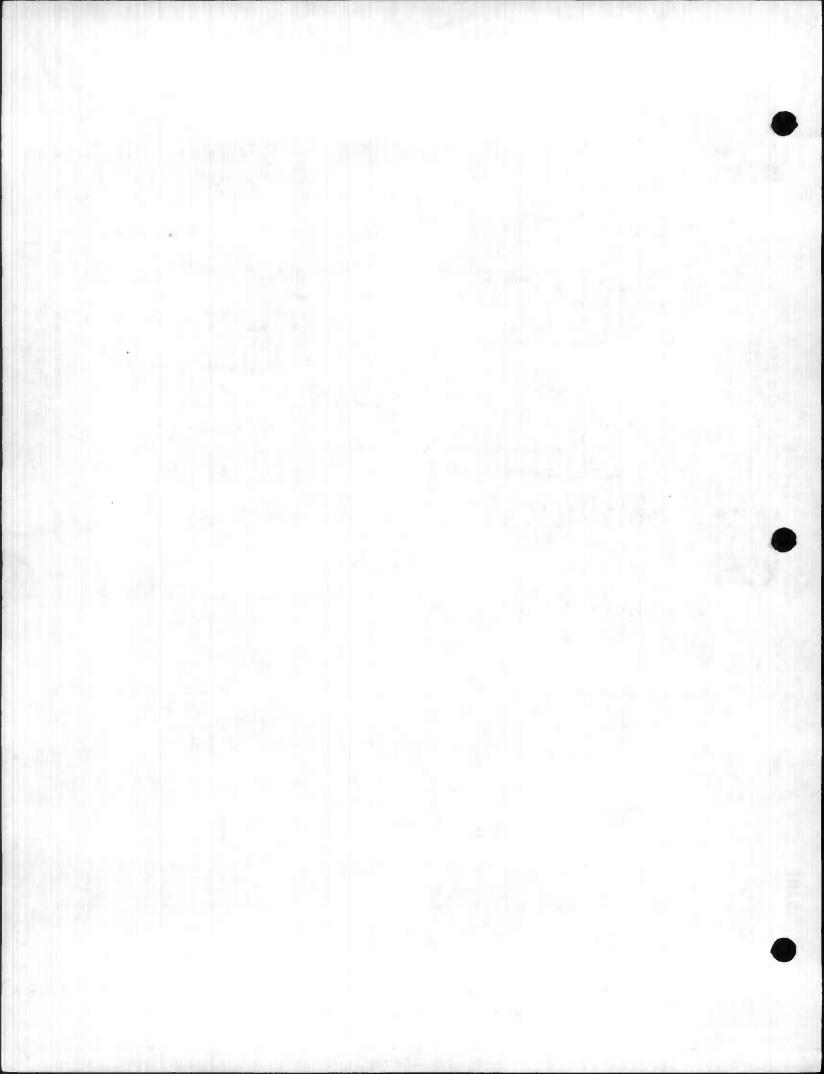
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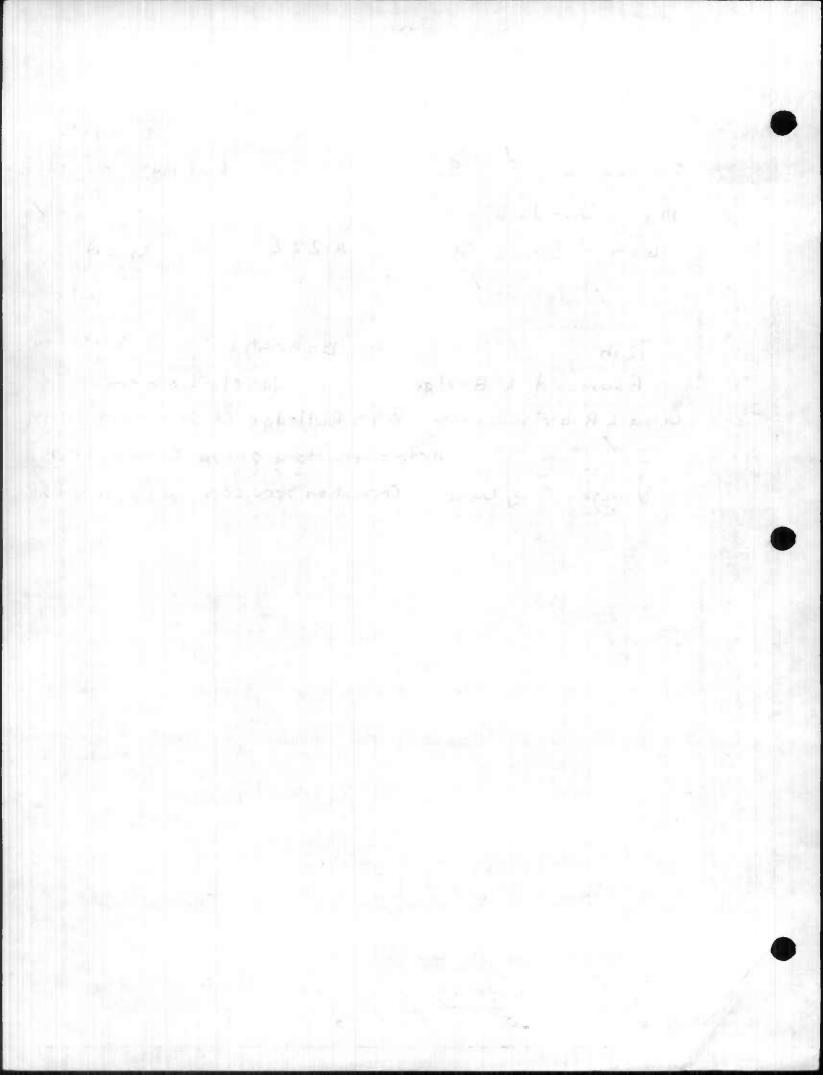
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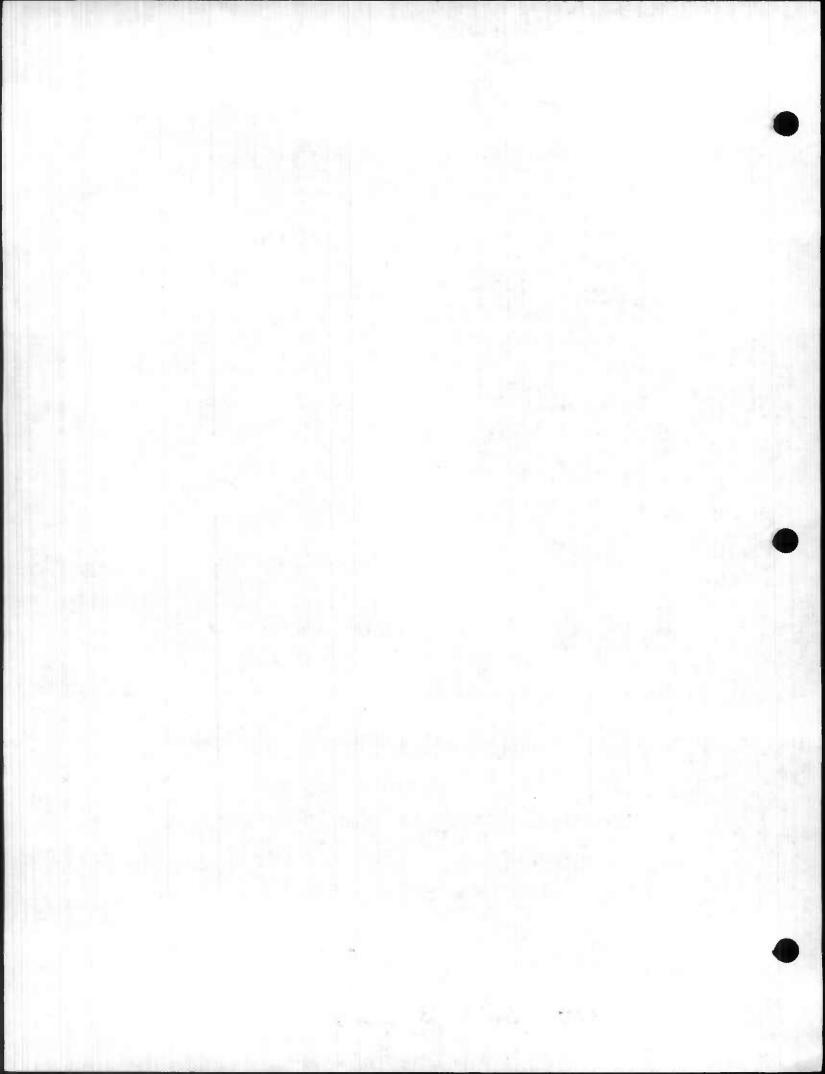
00-0876-510)	2/24/00 ygPlease Type or Print in Black Indelible	Ink. Assure A	II Copies	Are Legil	ble.
PATRICIA	A a	mend item 23a, State of Maryland / Department	of Health and N	Mental Hy	giene n	01.836
PUROL	27	, 28a,b,c,d,e,f, G780 Certificate	of Death		Reg. No.	0.7000
Physici	an	1. Decedent's Name (First, Middla, Last)		2. Dete of De Month	Dev	3. Time of Death
/Media		Patricia Lunn Pural	4b. City, Town, or L	FEBRUA:		
Examir	ner	4a Facility Name (If not institution, give street and number) 1635 ELRINO STREET	BALTIM			and alk
Funeral Director		5. Social Security Number 6. Sex 1 M 200 F 7. Age (In yrs. last birthday) If Under 1 S2 Yrs. Months		8. Date of Bir	2-1947	9. Birthplace (Stata or Foreign Country) Mary and
Jand Jand		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. tnside City Limits
Men.	ctor	md Dundalk				1 🗆 Yes 2 🗹 No
death with the Maryland ma 23e or 28e-f show mast be notified at	Funeral Director	10e. Street and Number 163 5 5. Elrino St	21222		10g. Citizen of V	what Country?
death	nera		ent of Hispanic Origin? (Sp ly Guban, Mexican, Puerto	ecity Yes or No	- 14. Rac	e - American Indian,
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural;, or thema 23e or 28e-f show any injury or other traumatic event, ins Wedical Examiner mass be notified appares.	by	1 Never Married 2 Married 1 Yes, Sive 1 Yes, Give Year or Dates:	/	rican, etc.)	Specify	k, White, etc. : White
72 ho	eted	15. Decedent's Education 16a. Decedent's Usuat (Specify only highast grade completed) (Giva kind of work	done during most of work	ing	16b. Kind of Bu	siness/Industry
21215-0020 d within 72 hours at giene. then 'netural', or the wedien Exem	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Domes!) c		NIA
ind failth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle		
Maryland d 2 should be file th and Mental Hy 7 Is merked othe treumatic event	7	Raymond L Baxtar 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Hq=	> 61	Lalhe	
Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If frem 27 is marked other than any injury or other traumatic event, the space.		LISA L Roberts Daughter 1895	Street and Number or Aut	- 1		md 21144
Baltimore, semit. Peges 1 er Department of Hea mportant: If item, iny injury or other these		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name cematary, crematory or other cematary).	ner place)	Dete		City or Town, State
Baltingemit. Per Department Important: any injury once.			Address of Facility	.14.200	Caro	nsuil < md
CO C		1) auch c otur Cremo	1	1605	13-14	more Nati Pile
		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	of dying, such as cardiac	or respiratory a		Approximate Interval Between
Physician /Medical		Immediate Cause (Finat				Onset and Death
Examiner		disease or condition resulting in death) a. DILTIAZEM INTOXICATI	ION			
7	ner	Due to (or as a consequence of):				
0, exacuted an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate				
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6876(ificate be g physicia as the bur	Physician/Medical	resulting in death) Lest Due to (or as a consequence of):				
Box 6 eath certifi attending	an/M	d				
P.O. BOX that the death cert ed by the attendin detached for use	ysici	Part II. Other algnificant conditions contributing to death but not resulting in the underlying car	use given in Part I.	23b. Did	tobacco use cor	ntribute to the cause of death?
that the ed by detac				10	Yes 2 No	3 Probably 4 Unknown
of Vital Records, P.O. Box 6876 Physician: The law requires that the death certificate be this certificate has been signed by the attending physicial director, page 2 should be detached for use as the but	Completed by				an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause
Rec he law he sage 2	dwo			Arx	Yes 2□No	of déath?
Vital Rysician: The Is scentificate his director, page	BeC	25. Was case referred to medical	26. Place of Deal			12 165 22110
Of V Physici this certhis certail direct	To	examiner? 1 🔾 Yes 2 🗆 No Hospital: 1 🗆 Inpatient 2 🗆 ER/Outpatient 3 🗆 DO/		ome 5 🕅 Resi	dence 8 □Oth	er (Specify)
□ ₽ ₽ ₽	ion:	Ciretatores Continued	c. Injury st Work? 1 ☐ Yes 2X☐ No	1	how injury occur	subject ingested
Division of or attending Physical death. Director: After this lin by the funeral di	ficat	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Piace of Injury - At home, farm, street, factory,		28f. Location (Street and Numb	er or Rural Route Number,
Div	Certification:	4 Homicide 28e. Piace of Injury - At home, farm, street, factory, building, etc. (Specify)		Baltimo	wn, State) 1635 re. Mil.	er or Rural Route Number, Elrino St.,
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai	1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examinetion and/or investigation, is and manner stated.		and due to the	cause(s) and ma	
vithin o the	Me	and married stated.	License number		29d. Date signed	d (Month, Day, Year)
		Mandockas)	C.M.E.		FEBRUAR	Y 13,2000
		30 Name and address of person who completed cause of death (ttem 23a) (Type, Print) 111 Pe	enn Street, 1	Baltimo	re. Marv	land 21201
Sta		31. Date flied (Month, Day, Year) 32. Begistrar's Signature				22274
Registr	ar	FEB 1 6 2000 American D. 1400				



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State of Maryland / Department of Health and Mental Hygiene

			Certific	cate of L	Death	F	leg. No.	04837			
	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death			
Physician /Medical	MELVIN T. PE'	TTY, SR.					10, 20	- GIRA AMA			
Examiner	4a Facility Name (If not institution, give	street end number)		4	b. City, Town, or Lo	ocation of Death	4c. County of	of Death			
	149 N. MILTON	AVE.			BALTIMO	RE	N/A				
uneral irector	5. Sociel Security Number 6. Se 220-20-8330	x 7. Age (In yrs. kg 71		nder 1 Yeer hths Days	If Under 24 Hrs. Hours Min.	(Month, Day	8. Date of Birth (Month, Day, Year) 2 / 1 9 / 28 9. Birthplace (Stete or Foreign Country) MD				
	Usual Residence of Decedent				·						
of all	10a. State 10b. County	10c. City	, Town or Location					10d. Inside City Limits			
notifie	MD N/A		BALTIM	IORE				1万Yes 2□No			
2 5	10e. Street and Number 149 N. MILTON	AVE.	100	f. Zip Code 2122	24		10g. Citizen of W	hat Country?			
Your must	11. Maritel Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. Was D	ecedent of H	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Rece	- American Indian,			
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	112 Yes 2 No If Yes, Give Year or Dates: WWII	1□ ٧	es 2 kg No		riceri, etc.)	Specify:	rck, White, etc. fy: WHITE			
Pe	15. Decedent's Edu	cetion	16a Decedent's	Usual Occupi	ation		16b. Kind of Bu				
Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give kind o	of work done of OT use retired	funing most of work	ing					
HO.	7	0	PRES	SMAN			SUN PA	PER			
Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumemi)			
0	unknow	n			un	known					
-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Malling Add	State, Zip Code)							
5	MRS. DOROTHY P	ETTY/WIFE	149 N.	MILT	ON AVE.	BALTO	., MD.	21224			
e di	20a. Method of Disposition	20b. Pl	ace of Disposition	(Neme of	1	Date		City or Town, Stete			
lury or	1 ⊠ Buriai 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State CED		CEME	ETERY 2/	14	balto.	, md.			
SUC SUC	21. Signature of Funeral Service Licens	to an a such	KACZ		SKI FUNE						
	23a. Part1. Enter the disease, or comp	lications that caused the death.	. Do not enter the	mode of dyin	ET ST. E	or respiratory ar	MD. Z	Approximate			
ian	shock, or heart failure. List only o	he cause on each line.						Interval Between Onset and Death			
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ner	diseese or condition resulting in death)				=MBOL1	564		15 MIN.			
- E			as a consequence					t			
dical Examin			PPLEG1								
Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	-	es e consequence					1			
	Cause (Disease or Injury that initiated events				E HEHO	MRHA	56	1			
edicai	resulting In death) Last	Due to (or	as a consequence	01):							
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be detached for use by Physician/A											
Physician/M	Part II. Other aignificant conditions con	ntributing to death but not resu	Iting in the underly	ing ceuse giv	en in Part I.	23b. Did t	obacco usa con	tributs to the cause of death?			
by Ph	Loronn	ny Anten	40158	156		101	108 20 No	3 Probably 4 Unknow			
							an autopsy	24b. Were autopsy findings			
et						репо	med?	evailable prior to completion of cause of death?			
Completed							es 2 No				
ပိ								1 ☐ Yes 2000 No			
8	25. Was case reterred to medicel examiner?	Hospital:		Oth Oth	26. Place of Deal	2.4					
To Be Compl	ILI TOS ZED NO	1 □ Inpatient 2 □ E		JOOA	4 Li Horsing m		lence 8 Othe				
0	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury		280. Describe r	now Injury occurr	9Q			
cat	2 Accident Investigation 3 Suicide 6 Could not be		М		Yes 2□No						
completely filled in by the funeral Medical Certification: 1	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, fa	actory, office		281. Location (S City or Tow	Street and Numb m, State)	er or Rurel Route Number,			
edical C	(Check only 2 Medical Exam)	sician: To the best of my know ner: On the basis of examineti									
Med	one)	end menner steted.									
2	29b. Signeture end title of certifier	40		29c. Licens				(Month, Day, Year)			
	Marchaffer	ompleted ceuse of death (Item **POELD HEALT H C 32, Registrar's Signel		13	7304		2-15-	-00			
	30. Name and address of person who co	ompleted ceuse of death (Item	23a) (Type, Print)								
	MARCSHAFMAN 1	WHELD HOWITH	CNIEN :	SAG A	24712/57	Bur	MD 21	224			
State	31. Date filed (Month, Day, Year)	32 Registrar's Signet	ure	0012		00001	1.19				
State legistrar	FEB 1 6 2000	She: "	. J. Se	racker							



	1. Decedent's Name (First, Middle, Las	1)		Certifica	01	20411	2. Date of De			Time of Death				
Physician /Medical	JOHN			R	OHR	BAUGI	+ FEBRU	Day IARY 13	Year 2000 0	525 an				
Examiner	4a Facility Name (If not institution, give	street and number)		*		4b. City, Town, or								
	THE JOHNS HOPKI	NS HOSPITAL	E CITY	NH										
Funeral Director	5. Social Security Number 6. Security Number 217-34-5063	8. Dale of Bi (Month, Di	rth ay, Year) 2 1938	9. Birthplace Country) Baltin	(State or Foreign									
show show	10a. Stata 10b. County	10	C. City, Town	or Location					10d. lr	naide City Limits				
hours effer deeth with the Maryland ural', or flame 23s or 28s-f show in Examination must be notified at id by Funeral Director	Maryland Anne Arı	ındel	Severn	a Park			1 ☐ Yas 2							
or 28	10e. Street and Number			10f. 2	ip Code			10g. Citizen of	What Country?					
23a 23a ral C	85 East Old Earlei	gh Heights	Road		2114	6		USA						
at, or tems 23a or 28a-1 s Exerciper must be notified by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNO If Yes, Give Year or Dates:	r in U,S.		edent of to secify Cub 2 CXNo	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or No no Rican, etc.)	5- 14. Rac Bla Specil	ce-American Inc. ck, Whita, etc. v: White					
ygiene. Nor then "neturn It, the Motes Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)		Decedent's Us Give kind of I We. DO NOT	vork done use retire	i during most of wo ad)	orking		usiness/Industry					
d other event, p	17. Father'a Name (First, Middle, Last)			averii	OWITE	T	me (First, Middle							
Mente arked To B	Charles Rohrbaug	jh				Helen	P. Dau	ghton						
Health and Mente than 27 is marked other traumatic ev	19a. Informant's Name/Relationship (7					t and Number or F								
Health Ram 27	Karen L. Rohrbaugh					Earleigh								
nent of H ant: If her ury or oth	20a. Method of Disposition 1 Burial 2 Cycremation 3 4 Donation 5 Other (Specify,	Hemovai Irom State			osition (Name of matory or other place) FeD. 15 Pale 20c. Location - City or Town, Pale 15 Pematory . Inc. 2000 Baltimore (la									
Department of Important: If I eny Injury or price.	21. Signature of Fuparal-Servicer Count	Metro Crematory, Inc. 2000 Baltimore, Harylan 22. Name and Address of Facility Stallings Funeral Home, P.A 3111 Mountain Rd. Pasadena, MD. 21122												
hysician /Medical ixaminer	23a. Part 1/ Enter the disease, or comp shock, or heart failure. List only of Immediate Causa (Final disease or condition resulting in death)	LIVER		ZHOS	15				Inter	roximata val Between et and Death				
n and sel-transk Examiner	Sequentially list conditions,	b. — Due	o to (or as a co	nsequence o	j):				1					
physicise the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue	to (or as a co):										
for us														
ed by the attending detached for use any Physician/M	Part II. Other significant conditions co	ntributing to death but n	ot resulting in t	he underlying				Yes 2 No	antribute to the	cause of death? 4☐Unknown				
ate has been signed by the page 2 should be detached.								an autopsy ormed?	available	utopsy tindings a prior to ion of cause ?				
pege 2 s							10	Yas 2 No	1 ☐ Yes	No				
s certificate he director, pege	25. Was case referred to medical axaminer?					26. Place of De	eath (Check only	one)						
	1 ☐ Yes 200 No	Hospital: 100 Inpatient	2 ER/Outp	atient 3 l	OOA O	her: 4 Nursing	Home 5 ☐ Rasi	idence 8 🗆 Ott	ner (Specify)					
or death. ector: After th by the funeral iffication:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Ye	28b. Tir Inj	ne of Iry M	28c. Inju Wo 1	ny at nk?] Yes 2 ☐ No	28d. Describe	how injury occur	red					
2 % E	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	Specify)				City or To	(Street and Numi wn, State)		te Number,				
within 24 hours a To the Funeral D completely filled I	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the best of m ner: On the basis of exa and manner stated	amination and/	leath occurre or investigation	d at the ti	ma, data and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and m data and place,	annar as stated. and due to tha	cause(s)				
within To the comp	29b. Signature and title of certifier	\cap		2	9c. Licen:	se number		29d. Date signe	d (Month, Day,	Year)				
10	30. Name and address of person who c	e MD	(Item 23a) (T	/pe, Print)	RES	5-000	3	FEBRUA	RY 13,	2000				
10	ANDREA C. SCHAR	FE DOCTOR'	SOFFI	E TO	WER	2110 20	HNS HOD	KINS I	t08P17H	Ł.				
State	31. Date tiled (Month, Day, Year) FEB 1 6 2000	32. Registrar'a	Signature				1 10		,					

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death AMEND#7 PER F.H. G780 2-16-2000 JAB Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev February 13,200 cation of Death Sarah Elizabeth Robinson 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death ATON MANOR GENESIS FUNDER BALTIMORE CITY
If Under 1 Year If Under 24 Hrs. 8. Dete of Birth J
Months Deys Hours Min. (Month, Dey, Ye ELDERLARE Birthplece (State or Foreign Country) Sociel Security Number 7. Age (In yrs. last birthdey) 1□M 2FF 214-26-5227 QQ Yrs. 09/29/1900 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore City 1 Yes 2 No Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2025 Etting Street 21217 U.S.A. 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Domestic Private Duty 8th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Daniel Waddy Elizabeth Waddy 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Earl Johnson/Son 3927 Annellen Road, Baltimore, Maryland 20b. Ptece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 XBurlel 2 Cremetion 3 Removel from Stete 2/17/00 Landsdowne, Maryland Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility 23a. Part 1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Cerebrouncular Accident /Dai tmmediete Causa (Finat diseese or condition resulting in deeth) Due to (or es e consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or es e consequenca of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Derten scon erebro vescular Seedent 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2□ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

Physician /Medical Examiner 68760

Box

Physician

/Medical

Examiner

Funeral

Director

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Items 23a

Directo

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other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or lary injury or other traumatic aware the second second second sec

ARAH E. Robinson

Examiner physician and the burial-transit Physician/Medical ģ Completed Be Certification: To

P.O. Records, Division of Vital or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun.

State Registrar

edical

29b. Signature and title of certifier Attending Doctor

D21684

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

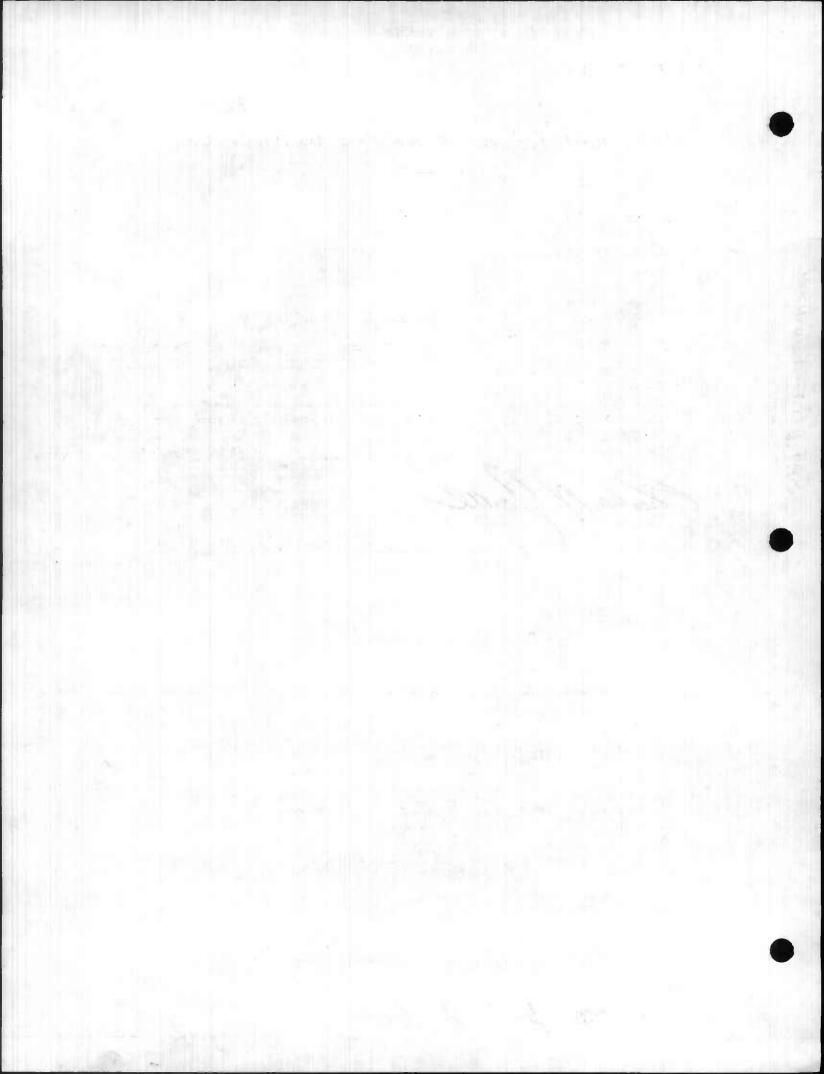
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C-V-CYRIAC. M.D, 8109 RITCHIE BWY, PASADENA,

31. Date tited (Month, Day, Year) FEB 1 6 2000

4 ☐ Homicide

29a. Certifier (Check only one)

> 32. Registrer's Signature oaks



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death FORWARY 13 mm. 45 edding ROSE MARY 2000 jon 4e Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death Lorien Nursing Home and Rehab. Center Columbia Howard County 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) 1□M 2QF Yrs. 214-14-7234 May 17 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Glen Burnie Md. Anne Arundel Co. 1 ☐ Yes 🔭 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7900 Benesch Circle Apt. 817 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Rece - American Indian, Black, Whita, atc. 1 ☐ Yas 2 X No If Yes, Give Year or Datas: 1 Nevar Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home Owner 12 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Alphonsa Melvin Vinyard Elizabeth Fenzel Horace 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7900 Benesch Circle Apt. 817, Glen Burnie, Md. 21060 James Louis Redding (Husband) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park 2/17/00 Glen Burnie, Md. 4 Donation 5 Other (Specify) 21. Signeture of Funerel Service Licensee 22. Nama and Addrass of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only one cause on aack line. Approximate Intarval Batween Onsat and Death Immediate Cause (Final disaasa or condition rasulting in death)

Physician /Medical Examiner

The law requires that the death certificate be axecuted

signe.

certificata

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within 24 hours after To the Funeral Direct completely filled in b Hospital

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Medical Certification: To

or Attending Physician: after deeth. Director: After this certifica

P.O. Box 68760

Records,

Division of VItal

Physician

/Medical

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10a. Stata

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Nema 23a

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altimore, Maryland 21215-0020

Pages 1 and 2 should be nent of Health and Mental

is marked

Department of Health a Important: If Item 27 Is any injury or other tra

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ð Completed

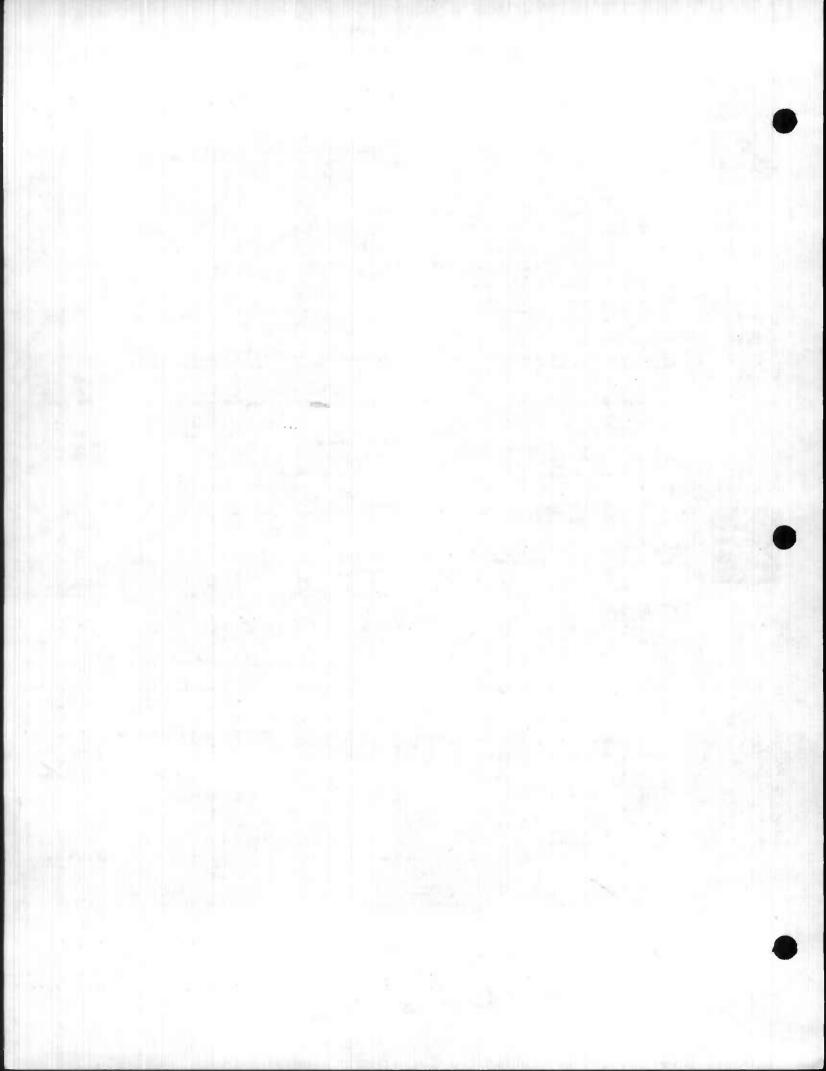
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1□ Yes 2 No 25. Was casa refarred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 GNatural 5 Pending investigation 1 Tas 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated.

29b. Signature and titla of certifier 29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

les Road Ellicett Cely

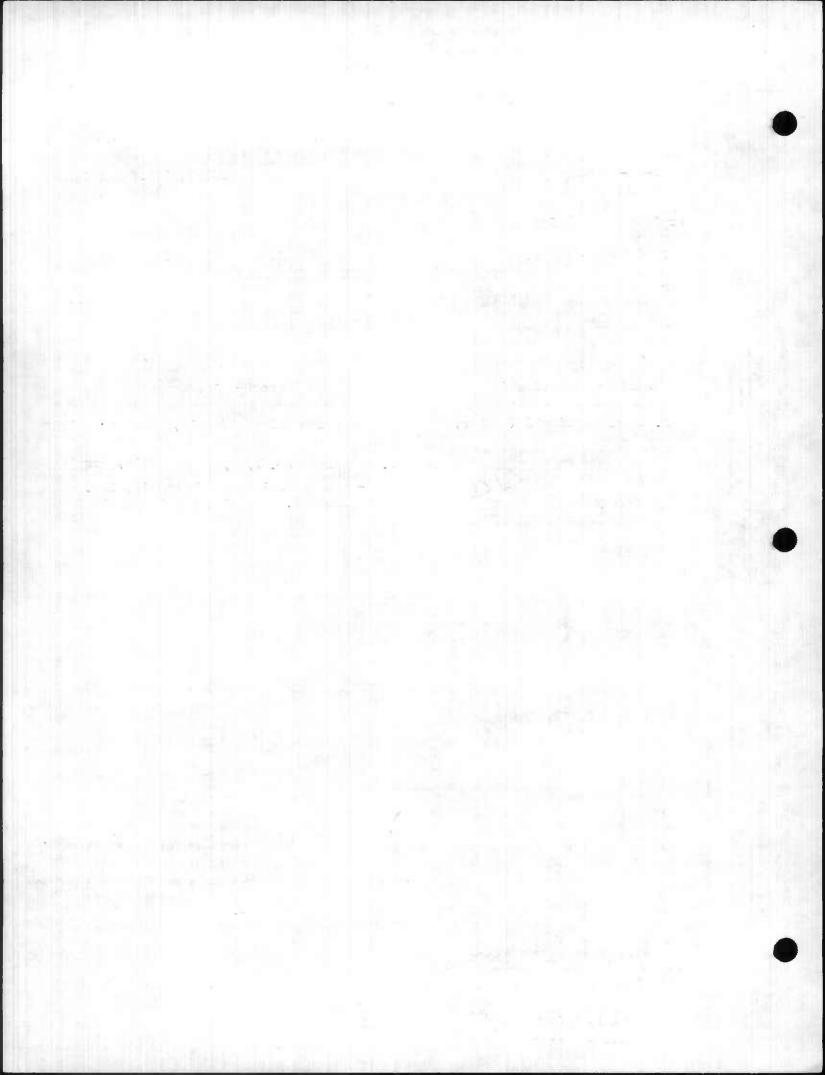


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State of Maryland / Department of Health and Mental Hygiene

1					Ce	rtificat	e of	Death		R	eg. No.	U	4041	
		1. Decedent's Name (First, Midd				Dent - 1.1					th Dev	Year	3. Time of Death	
5	Physician /Medical		Mich	nael Jam	James Rasinski					Month Februar	ary 10, 2000		10:41 A.M	
	Examiner	4a Facility Name (If not institution	n, give street and n	number)	4b. City, Town, or					ation of Death	4c. County			
												ltimo	re	
	Funeral	Months Davis House Min Month Da								8. Date of Birth		9. Birthp	lace (Stete or Foreign	
	Director	213-68-7789 12 M 2 F 46 Yrs. Months Days Hours Min. (Month, Day, Year) April 1, 1953											ryland	
	2	Usual Residence of Decedent		1						_			4	
	a how	10a. State 10b. County	/	10c. C	ity, Town or Lo	ocation						1	Od. Inside City Limits	
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	effer death with the Maryland or Neme 23e or 28e-f show miner ment be notified at / Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of \	What Cour	itry?	
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	ther death v	11. Merital Status	Armed F		J,S. 13.	Was Dece	dent of I	Hispanic Origon, Mexican,	pin? (Spec , Puerto R	city Yes or No- lican, etc.)		e - Americ ck, White,		
20	72 hours effer natural, or its died by Ful	Never Married 2 Mer	If Yes, C	3/3/No Give		1 Yes	201 No	Specify:			Specifi	v:		
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an	B S S S S S S S S S S S S S S S S S S S	Edward James												
Maryland 21215-0020	should be filed within and Mental Hygiene. • marked other than * · umatic event, the Mental To Be Completed.				10- 14-3	8 4 4	. 100	-		ny Cleo	*	Ctata Tia	Code	
<u>S</u>	d 2 should th and Men T le marke traumatic	19a. Informent's Name/Relation: Mr. Edward Ra							Route Number					
0	Heal Park	20a. Method of Disposition	SINSKI (F		Place of Dispo			riew Dr	rive		LK, Mar 20c. Location		21222	
Ö	2 7 0 2 7 0	1 8 Burial 2 ☐ Cremetion		n State	cemetery, crea	matory or o	other pla							
Baltimore,	permit. Pages 1 and 2 si Department of Health an Important: If Hem 27 is n any Injury or other traus phos.	4 Donation 5 Other (5		Sa	cred Ht					14/00	Dunda	1k, M	iaryland	
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	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1 Certifylic (Check only ane) 2 Medical	ng Physician: To th Examiner: On the l	basis of examina	owiedge, deat ation and/or in	occurred vestigation.	at the ti	me, date and opinion, deat	piace, ar	nd due to the c d at the time, d	ause(s) and mi late and place,	and due to	the cause(s)	
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	6	- Julyma	10 month	vill										
SA		30. Name and address of person	A A	use of death (Ite	m 23a) (Type,		n	- CL	٠.	Dalt.		7	3 21201	
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ROBINSON GEORGE FEDRUARY DOWALD 8:37 PM 10 2000 /Medical Town, or Location of Death 4c. County of Death silly Name (If not institution, give street and number) 4b. City. Examiner If Under Months Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days MXM 20 F 218-26-5918 Maryland Director 69 8/21/1930 Usual Residence of Decedent the Maryland r 28a-f show Inciting at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Dundalk 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 the Medical Examiner must be "natural", or Items 23a 21222 8125 Midhaven Rd. USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? ★IXYes 2□No If Yes, Give Year or Dates: Korea 11. Meritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be liked within 72 hours after Department of Health and Mental Hygers. Important: if Item 27 is marked other than "nature" any injury or other transmission. 1 □ Never Married 2 □ Merried Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3℃Widowed 4 Divorced Korea Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City Law Enforcement N/A 12th Grade 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Marie M. Brehm 2 George E. Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) (daughter) 8125 Midhaven Rd. Dundalk, Maryland Anita L. Martin 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11 top Service Corporation 2/15/2000 Towson, Maryland 21. Signatuse of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Pert. Enter the disease, or complications that counse the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting In death) /Medical PSELLDOMONAS BACTEREMIA Examiner Due to (or as a consequence of) Examiner attending physician and for usa as the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached á 1 Yes 2 No 3 Probably 4 Unknown peudis 8 by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has page 2 1 Yes 2 No 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical Be 26. Placa of Death (Check only one) Hospital: 1 Minpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending fnjury investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cratifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

Registrar

DHMH 16 Rev 6/95

FEB 1 6 2000

29b. Signeture end title of certified

MH 31. Date filed (Month, Day,

32. Registrar's Signature

ited cause of death (item 23a) (Type, Print)

oaks

29c. License number

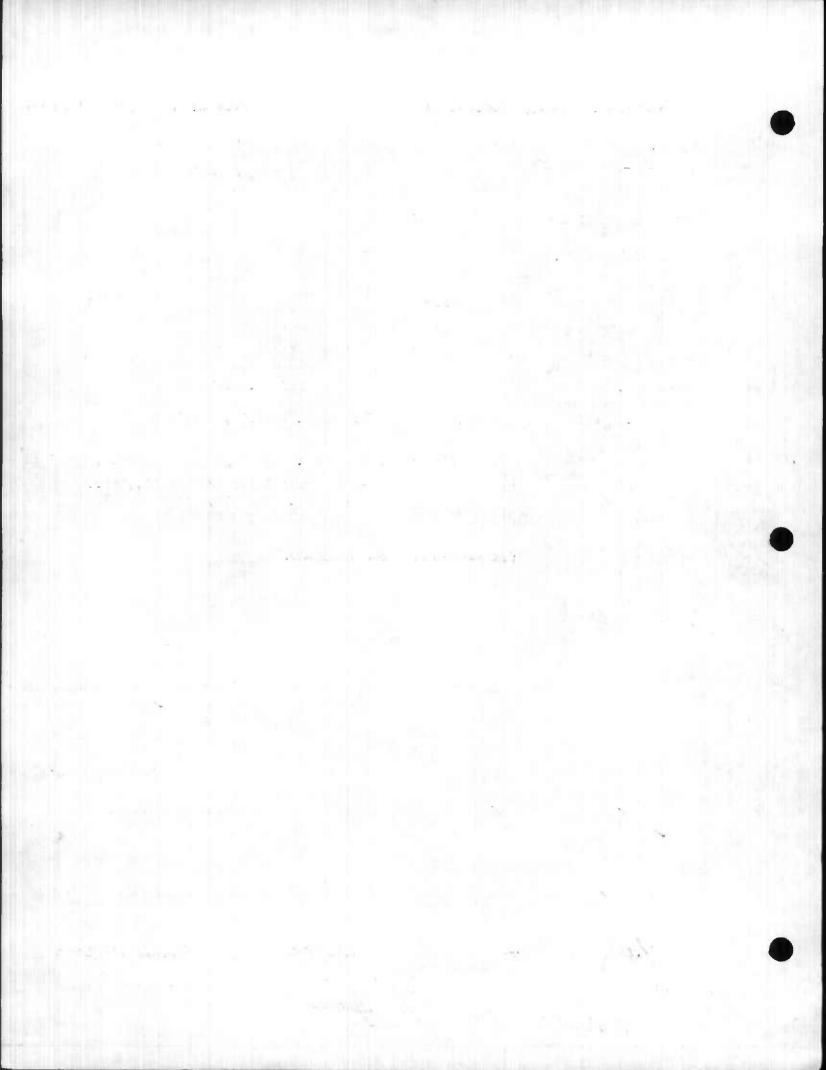
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29d. Date signed (Month, Dey, Year)

2000

FEBRUARY 10

ORIGINAL



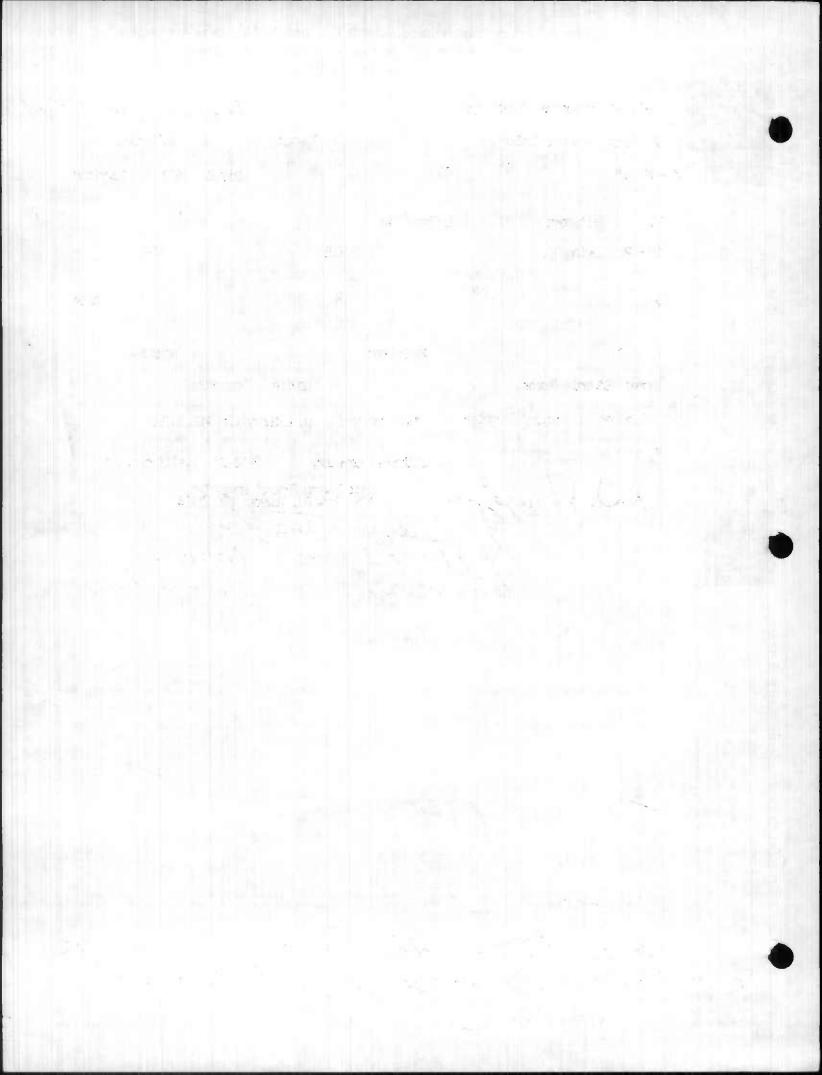
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0 dun Lillian Josephine Rosenberger /Medical 4b. City, Town, or Location of Death 4. County of Death 4a Facility Name (If not institution, give street end number) Examiner St. Joseph Medical Center Towson Baltimore If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F Months Days 99 220-44-2549 Director July 27, 1900 Maryland Usuai Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10h County 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director MD. Baltimore Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 1506 Pot Spring Rd. 21093 USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Riack White etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health end Mentel Hygiene. If item 27 Is marked other than "naturel", or item 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Thomas Edward Louise Rosensteel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mrs. Elizabeth R. Bigler/ Daughter 1506 Pot Spring Rd. Lutherville, MD. 21093 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 0 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 2-12-00 Baltimore, MD. 21. Signature of Funegal Service Lice 22. Name and Address of Facility Towson Funeral Home, York Rd. Towson, MD. any. 1050 York Rd. 23a. Part1. Enter the dise shock, or heart failur Approximate intervel Between Onset and Deeth **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Examiner 0 eroli requires that the death certificate be executed pue the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760 physician Physician/Medical Due to (or as a consequence of) USB 88 ettending Por 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. detached eu 1 Yes 2 No 3 Probably 4 Unknown à signed b Division of Vital Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy Completed peeu performed' has page 2 certificate 1 Yes 2 No 1 TYAS 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medicei Be 26. Place of Death (Check only one) examinar 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 DNatural Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Piece of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie who completed ceuse of death (Item 23a) (Type, Print) Hom ad address of person DNACIM 31. Date filed (Month, Day, Year) 32. Registraris Signature State FEB 16 2880 Registrar

DHMH 16 Rev 6/95

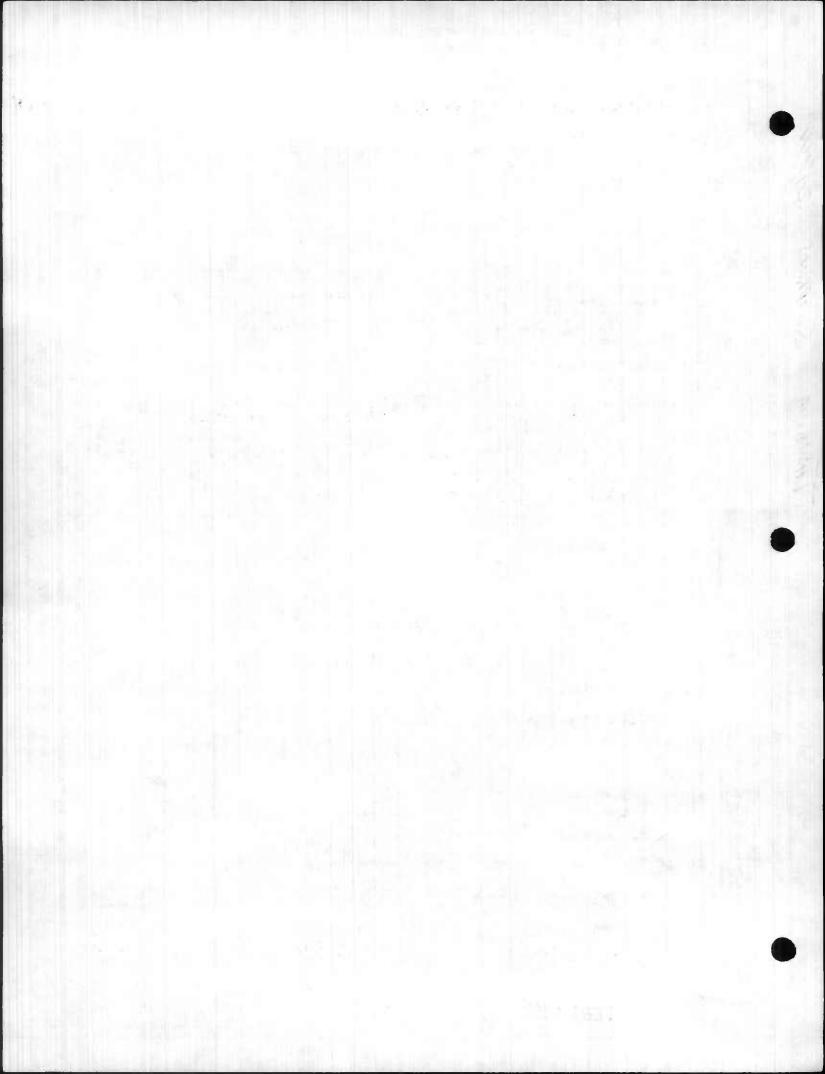
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Year Month **Physician** nomasine :30 AN Doce d /Medical Ac. County of Death Prince George 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 14732 4th Street Laurel If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplaca (State or Foreign Country) Funeral Months Days Min. Hours 10 M 2 KF 78 214-03-0628 Yrs. Director 12/31 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow MD Prince Georges Laurel XX Yes 2 No Director r than "natural", or items 23s or 28s-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14732 4th Street 20707 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. 11. Merital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 ☐ Married 1 ☐ Yes ZXX No Specify: Black Baltimore, Maryland 21215-0020 Specify: à 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Department of Health and Mental Hygu Important: If item 27 is marked other 17 Father's Neme (First Middle Last) 18 Mother's Neme (First Middle Meiden Sumame) Be Pages 1 and 2 should be next of Health and Mental Jesse Jackson Rose Uhk. Maiden Name 2 HOW STWOH 19e. Informent's Name/Relationship (Type, Print)
Rose Grady / Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14732 4th Street, Laurel Maryland 20707 20b. Place of Disposition (Name of cometery, cremetory or other place)
St. Peters Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete February 19, 2000 Pittsburgh, PA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Paltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit. Approximete interval Between Onset and Death **Physician** /Medical immediate Cause (Finel nonth diseese or condition resulting in death) Examiner NOV attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last un Box 68760. Physician/Medical Due to (or es e consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 94 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records. p 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to Completed Deen completion of cause of death? page 2 s 1 Yes 2 No 1 Yes No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 1 Yes 2 No 10 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth
1 Selectural
2 Accident funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After t 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only one) 29b. Signature and time of certif 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) havrel 831 Lee MI 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State 2000 FEB16 Registrar **DHMH 16 Rev 6/95** 2001

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth OZ-**Physician** VANDALE EMMA 10000AM /Medical 4a Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 21, 1907 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months 186-44-4967 1 □ M 2 1 F 92 **Director** Usuel Residence of Decedent with the Maryland 10a. Sfafa 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 1 ☐ Yes 2000No Directo 28s-f 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 23a or 228 Wiltshire Lane 21146 United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, apecify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ğ 3 ₩ Widowed 4 Divorced Year or Detes Be Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary Law Office 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 ahould be fill ment of Health and Mental H ant: If item 27 is marked oth lury or other traumatic even Vandale Peter Malina Mouton 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Howard Stevens / Son 228 Wiltshire Lane Saverna Park Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Department of Important: If any Injury or Oak Spring Cemetery Feb. 19, 2000 Canonsburg, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name end Address of Fecility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230 23a. Part 1. Enter the disease, or complications that cause the death. Do not antar the mode of dying, such as cardiac or respiretory arrest, shock, or haer failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final NEUMON disease or condition resulting in death) Examiner The law requires that the death certificate be assecuted tha bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Box 68760, Be Completed by Physician/Medical be detached for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? wey 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case rafarred to medical axaminer? 26. Placa of Death (Check only ona) 1 ★Inpatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 27. Manner of Death 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) After 5 Pending investigation 1 Natural 2 Accident To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 1x Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifian On the basis of examinetion and/or investigetion, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Dete signed (Month, Day, Year) Title of certifier 29c. License number 29b. Signature a 02-15-00 Franklyn < Cathedral Street Annapolis, 21401

DHMH 16 Ray 6/95

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32. Registrar's Signatura

Japana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

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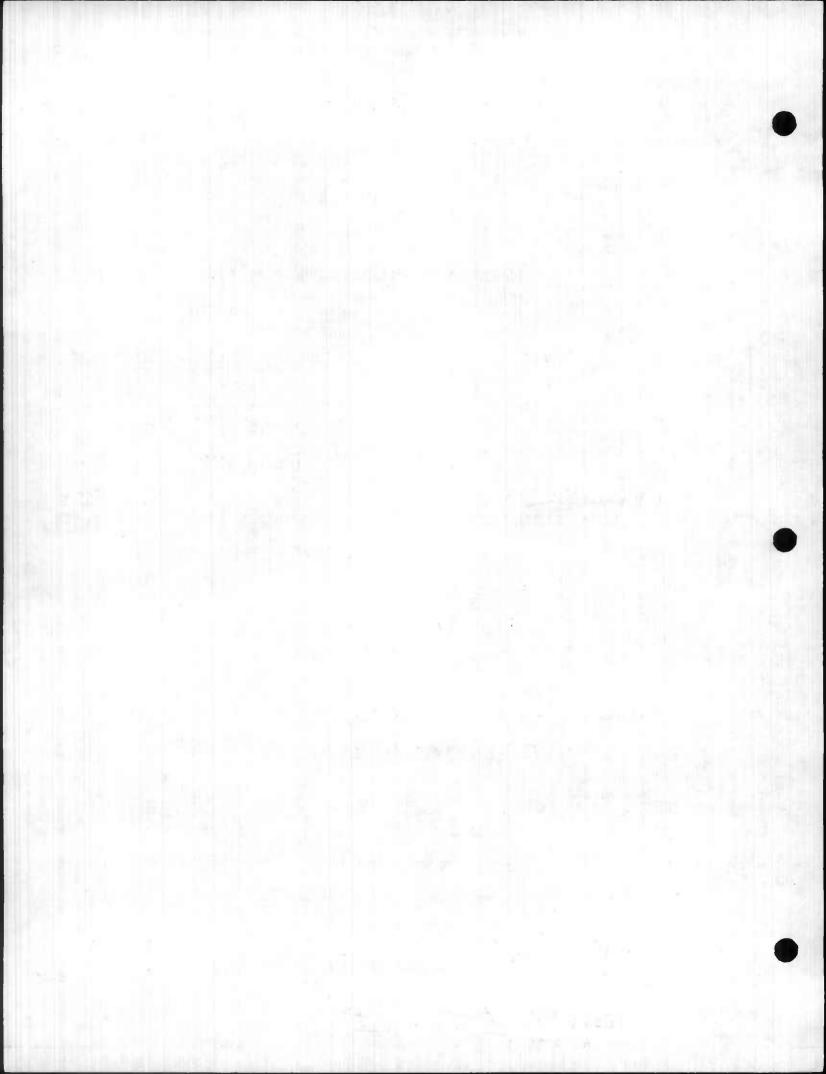
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ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Dafe of Death Month 700 Am LOUISE SMITH FEBRUARY 2000 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death HOSP ITAL BALTIMORE AGNES BAT (MORE COUNTY If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys Hours 1□M 2₩F 92 Min 220-20-8324 10-23-07 MD Usual Residence of Decedent 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Edmondson Avenue 21228 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Meritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: Black 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) llthGrade Domestic Work NA Temple Pierce Co. 17 Father's Name /First Middle (ast) 18. Mother's Name (First, Middle, Meiden Sumeme) Frank Meade Sally Johnson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21212 19e. Informent's Name/Relationship (Type, Print) Renee Mills 4806 Crowson Avenue Baltimore, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State MD 20a. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest VA Cem. 02+22-2000 Owings Mill Signariae of Funeral Service Lice 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediata Cause (Final disease or condition resulting in deeth) adder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Renal Due to (or es a consequence of) 23b. Dfd tobacco use contribute to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I 1 Yes 2 No 3 Probably 4 Winknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Manger of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigetion 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Box 68760 Division of Vital Records, P.O. or Attending Pi after death. Director: After th

Physician

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Examiner

Director

Funeral

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7 is marked other than "natural", or hams 23s or 28s-f show traumatic event, tre Moulcal Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Introcrant: If Item 27 is marked other than "natural", or ther any Injury or other traumatic event.

Physician /Medical

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29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0020

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death

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within 2

State

Registrar

ABENA 31. Dete filed (Month, Dey, Year) FEB16 2000

29b. Signeture and title of certifier

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Anso ms

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32. Registrer's Signeture Tener

DOLKS

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

11359

. ST. AGNES HOSPIAL, CATON NE, BALTIMORE,M

FEBRUARY 13, 2000

29d. Date signed (Month, Day, Year)



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Please Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month TEVENS February 4b. City, Town, or Location of Dead , 2000 12:05 Am 4c. County of Death 4a Facility Neme (If not institution, give street end number) St. Elizabeth Nursing Home If Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 KF Days Hours Min. 181-14-2968 Yrs 26,1913 86 Pennsylvania Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County MXYes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21229 1820 South Caton Avenue Apt. 30 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: White 3- Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decèdent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Licensed Practical Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Joseph Callan Mary Teresa Bender 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 226 Hazel Avenue Lansdowne, MD 21227 Rose Ann Myers (Daughter) 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 2⊠Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 2/18/00 Elkridge, MD 21. Signature of Funeral Service Licanian 22. Name end Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the deeth. Do hot enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Finei disease or condition resulting in deeth)

Physician /Medical Examiner

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Physician

/Medical

Examiner

10a. State

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the Maryland

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filed within 72 hours efter

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any Injury or other traumatic event, page.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/Medicai Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did lobacco use contribute to the cause of death? Insulin Diabetes, Parkinson 1 Yaa No 3 Probably 4 ☐ Unknown þ 24b. Wera autopsy findings available prior to completion of cause of deeth? ession, Left hip fixation 24a. Was an autopsy performed? Completed Castro e sophages Refluy Discuse 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 27. Menner of Deeth 28d. Describe how injury occurred Certification: Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. edicai 29e. Certifier

sician and burial-transit the attending physician Box 68760 the 8.8 P.O. Records, Division of Vital death. **Director:** 24 hours after of To the Hospital within 24 hours a To the Funeral D

State

29b. Signature and title of certifier

29c. License number

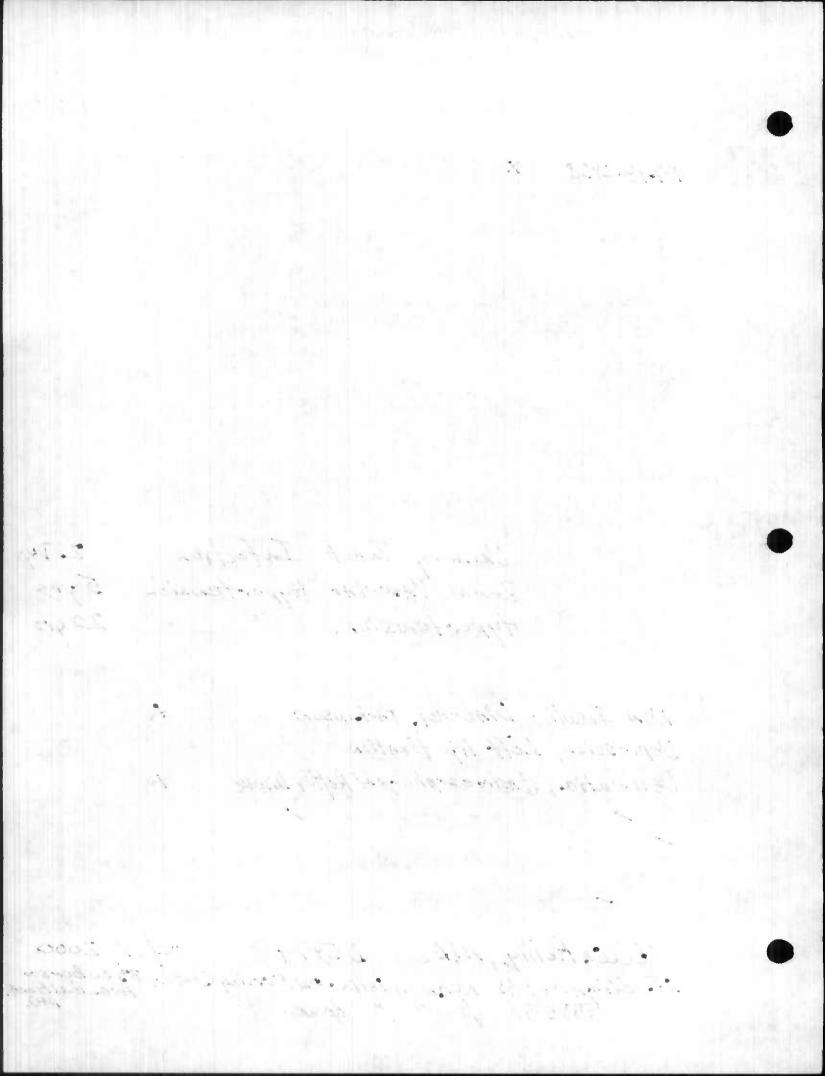
29d. Dete signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

Rehabilitation and Norsing Center.

33 20 Berson

Registrar **DHMH 16 Rav 6/95**

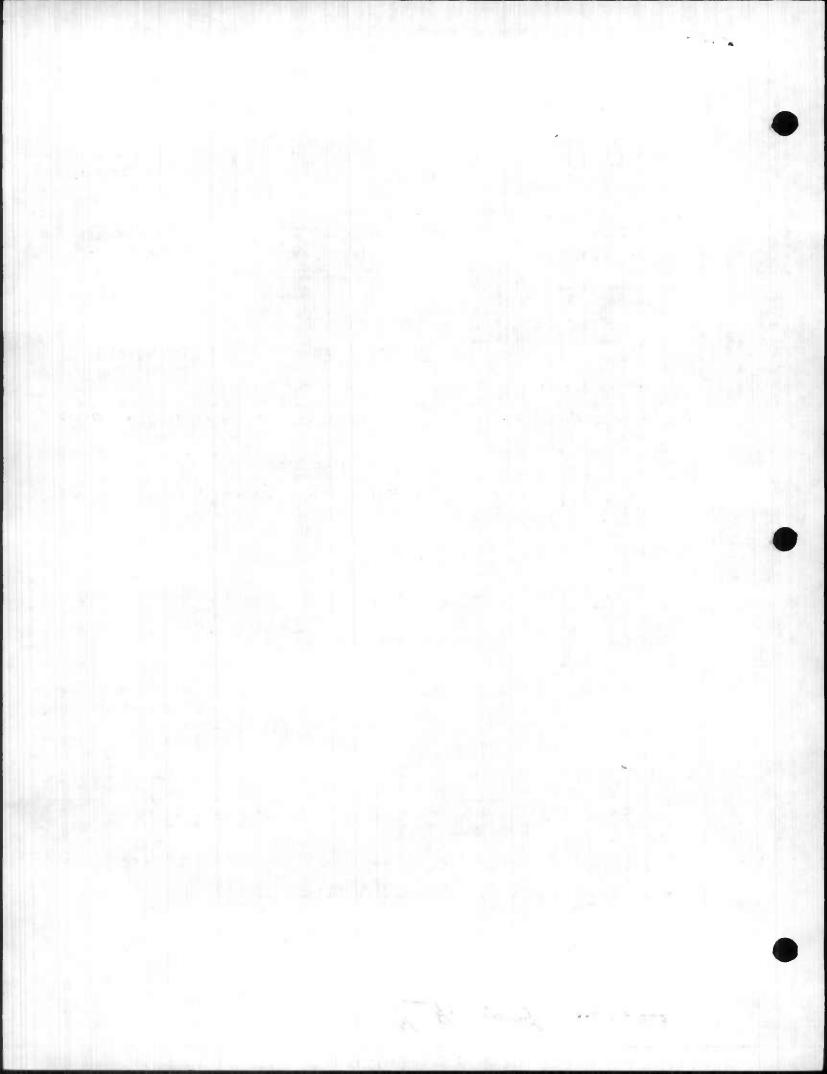


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State of Maryland / Department of Health and Mental Hygiene

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	Physician /Medical	1. Decedent's Name (I		Fe			2. Date of Dea Month February	Day	Day Year		Death			
	Examiner	4a Facility Name (If no 602 Overbr		street and numbe	er)				b. City, Town, o Baltimo	r Location of Death	4c. County Balt	of Death		
	Funeral Director	5. Social Security Num 405-20-920	1 1X	7. /] M 2□ F	Age (In yrs. 75	last birthday) Yrs.	If Under	1 Year Days	If Under 24 H Hours Mi		1924	9. Birthple Count Kenti	ace (State or ry) JCky	Foreign
Maryland	a-f ahow Uned at		Baltimor	e		y, Town or Loc						10	od. Inside City	
ath with the	123a or 28a-f al nust be notified real Director	10e. Street and Number					101. Zip (12			Og. Citizen of V	State	es	
020 urs efter de	natural', or fama 23a or 28a-f ahov rdical Examinar must be notified at leted by Funeral Director	11. Marital Stetus 1 Never Merried 3 Widowed 4		12. Was Decede Armed Force 1 ZWes 2 [If Yes, Give Year or Dates	s? TNo		/as Decede Yes, speci	9.0	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		e - America ck, White, e	tc.	
21215-0020 d within 72 hours efter death with the Maryland		(Specify Elementary/Seconds	i. Decedent's Edu only highest grad ary (0-12)	cation completed) College (1-4c			ind of work O NOT use	k done d e retired	ation furing most of w	rorking	16b. Kind of B		ustry	
CA DI	marked other than imatic event, tha M To Be Comp	12 17. Father's Name (Fir William St		5+		Liecu	rical			ame (First, Middle,				
Z 2	0 8 2 8	19a. Informant's Name Mrs. Doroth	A/Relationship (Ty	pe, Print)	fe			(Street	and Number or	Rural Route Numbe Baltimore			Code) 21212	
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Balt Pemit.	Important: H any injury or poce.	21. Signeture of Funer	al Service Licens	* Christin	a L. Di	7/1				eonard J. Raltimore, Ma				
///	ysician ledical aminer	23a. Pert1: Enter the c shock, or heart fa Immediate Cause (Fin disease or condition resulting in death)	ailure. List only or	cations thet cause on aach	Co	M CLL or as a consequent	lear	of dying	g, such as card	iac or respiratory an	est,	1	Approximate Intervel Betwoonset and D	veen
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of Vita Physician:		25. Was case referred axaminer? 1 Yes 25 No 27. Menner of Death 1 74 Accident	ER/Outpatient 28b. Time of Injury		Sc. Injun	er: 4 Nursing	Homa 5 Residence 28d. Describe h	ence 6 Oth)				
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n n	Me Me	29b. Signature and title	M)					848 -	7	2//s/	d (Month, E	Day, Year)	
H	W	30. Name and address	THANT	68	30	to spi		D	RIVE,	BALTO	MD	212	37	
	State Registrar	31. Date filed (Month, I	Day, Year)	32. Regis	itrar's Signa	iture	- 4							

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death 130 MARGUERITE SPLIED E 12000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 03 57. ACT MORE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month. Day, If Under 1 Year Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 215-09-1□M 2×F Months Days 10/3 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? SRUND 21224 803 5. 12. Was Decedent Evar in U,S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0/12) College (1-4or 5+) KER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FORWARD 19a. Informant's Neme/Relationship (Type, Print 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IMOKE, MD. 21206 -OUISE 20b. Place of Disposition (Name of cametery, crematory or other p 20e. Method of Disposition 20c. Location City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Furniral Service Ligensee Name and Address of Facility 3218HL 23a. Part1. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Fine) Myoundal disaasa or condition resulting in death) Due to (or es a consequence of): perli DIP Emil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TRO pazoni OTTO AUTVINE 2√ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa SQ Residence 6 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Neturel 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner Examiner Division of Vital Records, P.O. Box 68760 Physician/Medical þ Completed Be Medical Certification: To ž al or Attending F after death. I Director: After After

To the Hospital within 24 hours a To the Funeral Completely tilled

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural" ~ "natural" once any injury or other traumatic available.

Physician /Medical Director

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Completed

DHMH 16 Ray 6/95

State Registrar

29e. Certifier (Check only one)

29b. Signetare and title of certifian

DIMON

31. Date filed (Month, Day, Year)

110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

32. Registrar's Signature

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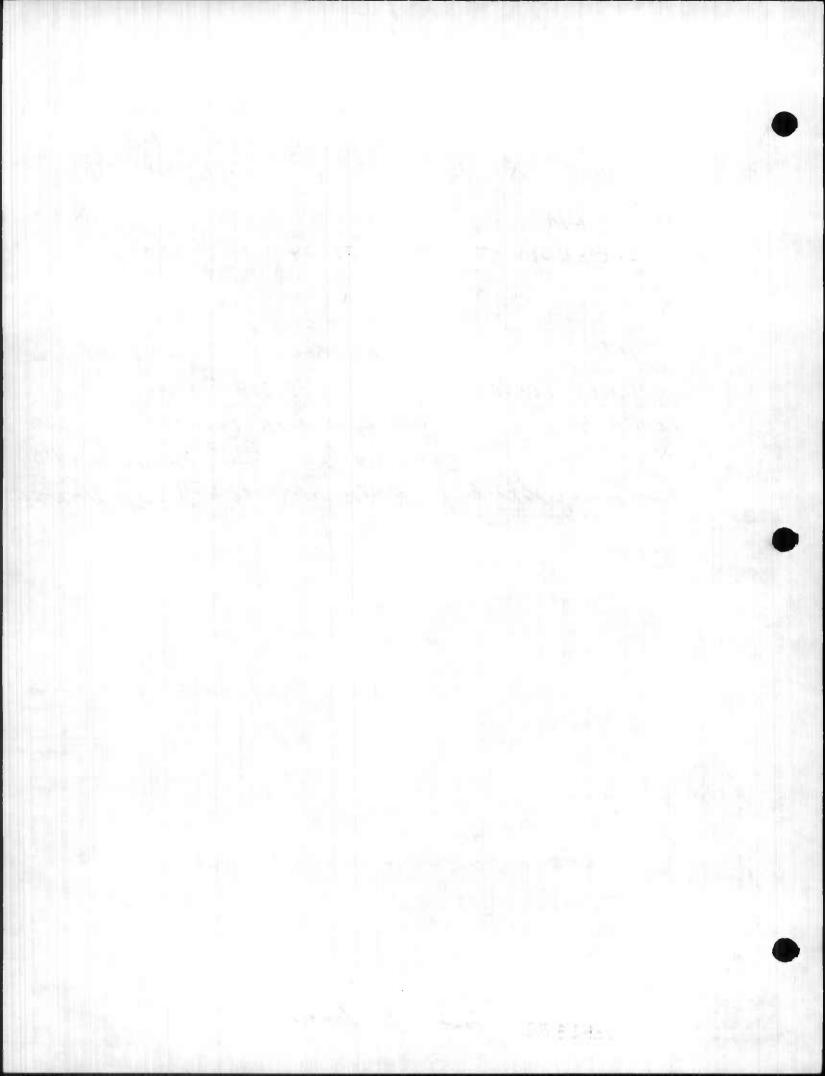
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D24276

29d. Date signed (Month, Day, Year) 00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier ? Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Year **Physician** 02 11 2000 10:30am Simms Jr. | UZ . 4b. City, Town, or Location of Death Charles /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3601 Clarks Lane Apt 607 Baltimore If Under 1 Year If Undar 24 Hrs.

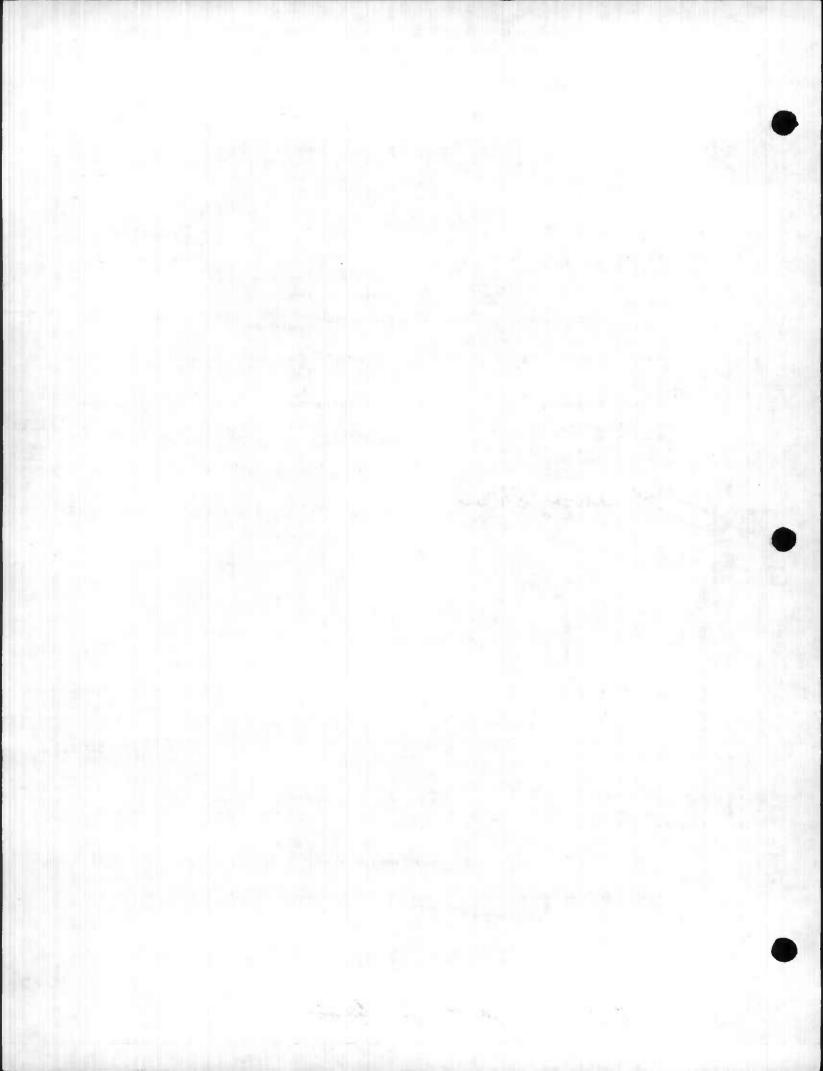
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Days 1X M 2□ F Yrs. Director 216-24-6392 M.D. Usuai Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "netural", or flems 23s or 28s-f show Wes 2 No Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 Clarks Lane Apt 607

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? U.S.A.

14. Race - American Indian,
Black, White, etc. Funeral 21215 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If ham 27 is marked other than "natural", or from any injury or other traumatic avant, the Medical Exemples. 1 Yes XINO If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: 3□Widowed 4□Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Mill Side-Checker Beth Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lo Charles Simms Sr. Natalie Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Pierce-Daughter 3601 Clarks Lane apt 607, Baltimore Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 XBuriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery
22. Nama and Address of Facility 2-17-00 Baltimore, Co. 21. Signature of Funeral Service Licensee March F/H West 14300 Wabash Ave. Baltimore Md. one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Enter the diseas or heart failure. Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) 71015 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): . Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? wheter, Periphine Vasculor Cliscose 1 Yes 2 No 3 Probably 4 Unknown ped i Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 PNo 1 □ Yes 2 □ No. of Vital or Attanding Physician: 25. Was case referred to medicat examiner?
1 ☐ Yes 2 ☑ No 8 26. Place of Death (Check only one) Hospitat: 1 Inpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Naturai 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital To the Hospital within 24 hours or To the Funeral completaly filled edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bensh, mr 21 (voss , oach B. buing milts, mu 21117 Sumuel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB16 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year SMITH 6:47 MELVIN FEBRUARY 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 8. Data of Birth (Month, Day, Year) Sept. 18,1917 If Under 1 Year 9. Birthplaca (Stata or Foreign Country) Maryland If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Days Months Hours 82 217-26-2487 Usual Rasidence of Decedant 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Edgemere Baltimore 1 TYAS 2 NO Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 21219 United States 6606 North Point Road 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas?

1X Yes 2 No If Yas, Giva 14. Race - Amarican Indian, Biack, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 Widowed 4 Divorced WWII Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Rail Road 10 Years Car Inspector 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Lottie Ambrose Lewis Smith 19a. Intermant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21219 6606 North Point Road Edgemere, Maryland Mrs. Frances G. Smith (Wife) 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 Buriai 2 □ Cramation 3 □ Ramoval Irom State Holly Hill Mem. Gdns. 2/15/00 Middle River, MD 4 Donation 5 Other (Specify) 21. Signatury of Funeral Service Licensee 22 Name and Address of Facility al Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximata Intarvai Between Onset and Death 72 hours Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4) Unknown 1 Yes 2 No 3 Probably 24b. Wera autopsy tindings available prior to 24a. Was an autopsy parformed? completion of cause of death? 25. Was casa ratarred to medical axaminar? 26. Place of Death (Check only ona) 1 □ Yas 2NNo Hospital: Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1) Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

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should be filed within 72 hours after and Mental Hygiena.

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Baitimore, Maryland 21215-0020

Examiner Physician/Medicai à Completed Be Certification: To

sician and burial-transit The law requires that the death certificate be axecuted Box 68760. the Division of Vital Records, P.O. signed by the been si page 2 s Hospital or Attanding Physician: this After death. after deatl Director: filled in 24 hours a

To the Hosp within 24 hos To the Fune completely fi

State Registrar

Medical

31. Data tiled (Month, Day, Year)

27. Mannar ot Death

Naturai

2 Accident

3 Suicida

29a. Certifier

4 Homicida

(Check only one)

5 ☐ Pending

invastigation

6 Could not be determined

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) PYNADATH ELIZABETH THOMAS

28a. Data of Injury (Month, Day Year)

29c. License number RES-000

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year)

Location (Street and Number or Rural Routa Number, City or Town, Stata)

28h Time of

28a. Placa of Injury - At homa, tarm, street, tactory, office building, atc. (Specify)

Johns Hopkins Bayview Medical Ctr.

28c. tnjury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

4940 Eastern Blvd. Baltimore, MD

28d Describe how injury occurred

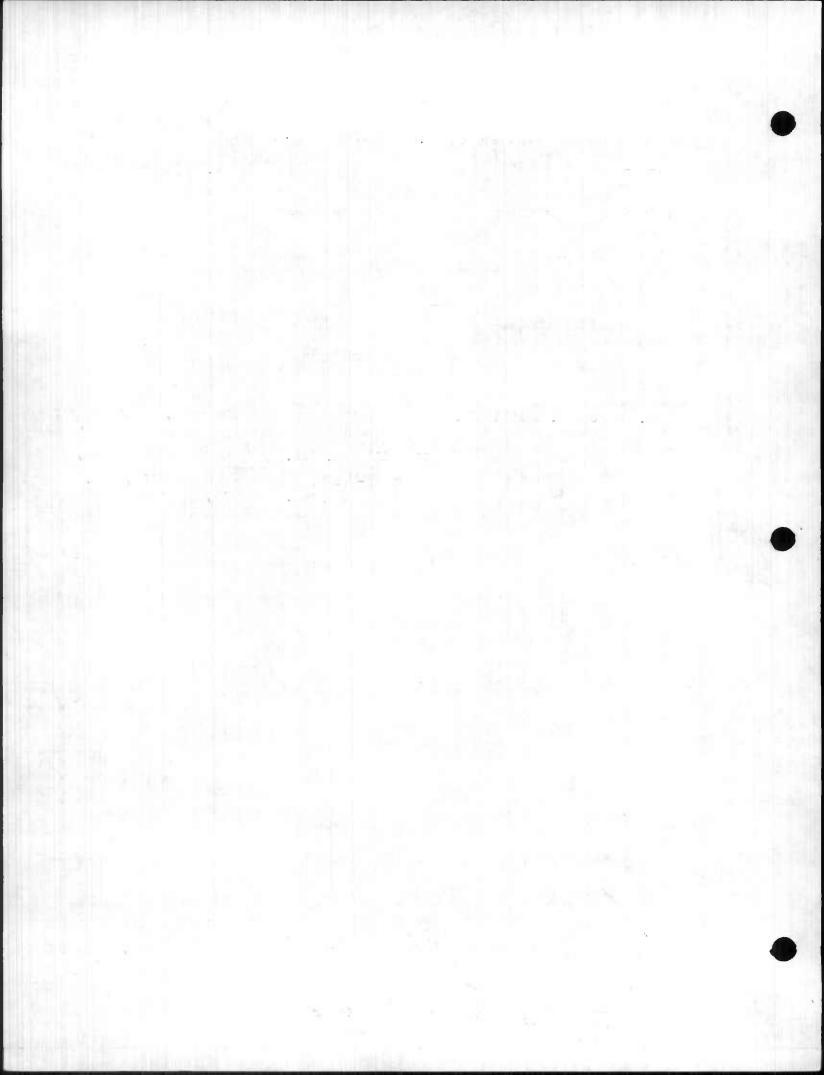
29b. Signatura and titla of certifier

32. Registrar's Signatura

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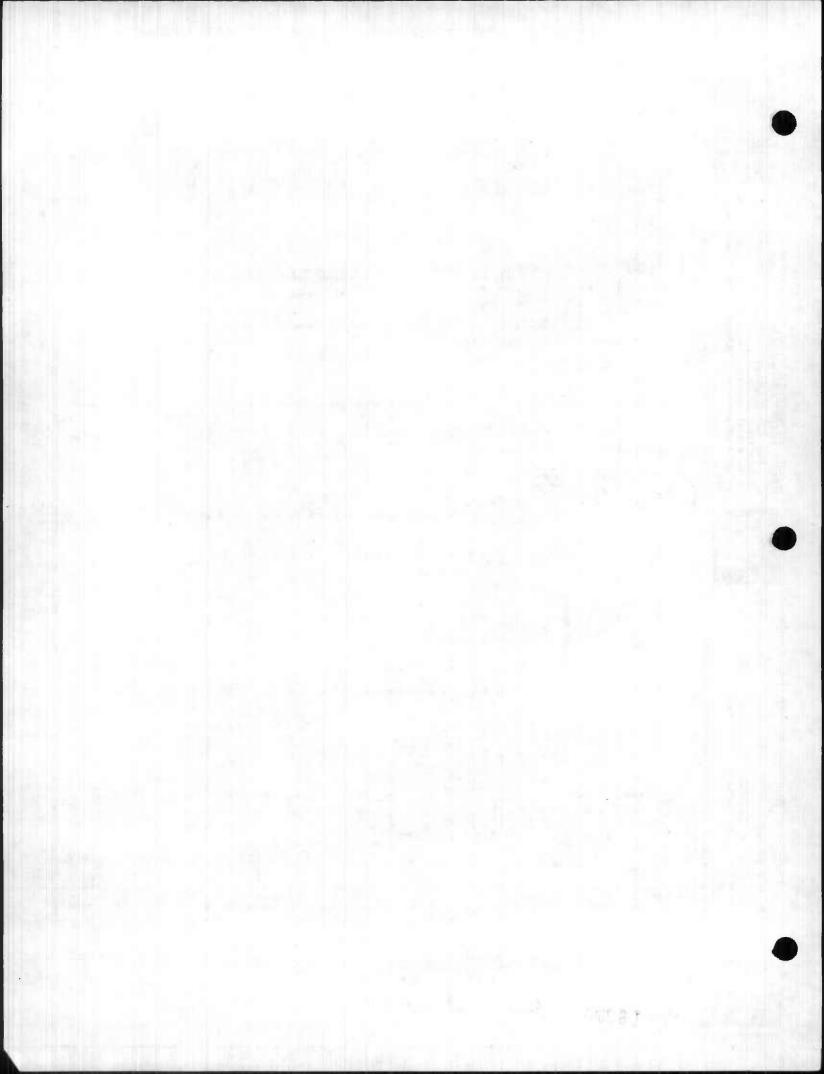
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/Medic		4a Facility Name (ff i	not institution, give	street and numi	ber)			4t	c. City, Town, or	Location of Deat		-	0110
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Funeral		5. Social Security Nul		M 200 F	. Age (III yrs	Vre		Days	Hours Min	(Month, Di		Count	ace (State or Foreign try)
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4 2 2	- e	10e. Street and Numb	er				10f. Zip C				10g. Citizen of \	What Count	iry?
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in the second	١٥	1 Never Married	25 Married	Armed Ford		If	Yes, specif	y Cuban	, Mexican, Puer	to Rican, etc.)	Blac	ck, White, e	itc.
21215-0020 d within 72 hours aft plene. if than "natural", or	by	3 ☐ Widowed 4		If Yes, Give Year or Dat		1	☐ Yes 2[No No	Specify:		Specify	V:	White
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IOCE, Maryland 212. ges 1 and 2 should be filed within t of Health and Mental Hygiene. If Itam 27 is marked other than or other traumatic avant, the Me		Floyd Mitchell								Bernice Folger			
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Stat Registra	_	31. Date filed (Month,	Day, Year)	Seres De	gistrar's Sign	ature 400	etas						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month E. Stehlik Anna tebruary 11,2000 4e Facility Neme (II not institution, give street end number) 4b_City, Town, or Location of Death 4c. County of Death Baltimore Kosedale If Under 24 Hrs. 8. Dete 7. Age (In yrs. last birthday) enter tranklin Square ff Under 1 Yee 8. Dete of Birth Month Dev Year 08/18/1914 5. Social Security Number 9. Birthplace (State or Foreign 1 M 2 F Days Hours 85 213-03-9347 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21221 United States 538 Fuselage Avenue 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ñ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11. Meritel Stefus Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) William Foxwell Camella Thiel 19a. Informant's Neme/Retetionship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 538 Fuselage Avenue, Baltimore, Maryland Mr. Joanne C. Izzo/Daughter 20b. Place of Disposition (Name of commetery, cremetory or other place) Bohemian National Cem. 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removel Irom State Deta 20c. Location - City or Town, Stela 02/15/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Christina L. David 22. Name end Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214 aud 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errast, shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onset and Death · Acute Myocardial Infarction trimediata Causa (Finat diseese or condition resulting to death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es e consequence of) Due to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Diabetes Mellitus, 1 Yaa 2 No 3 Probably 4 Unknown 00 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be

Examiner ician and burlal-transit The law requires that the death certificate be assecuted physician the burla Box 68760 for use Division of Vital Records. P.O. or Attending Physician: this After to Hospital or Attending in 24 hours after death. The Funeral Director: Aft pletely filled in by the fur

Physician

/Medical Examiner

Physician

/Medical

Examiner

MD

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mentel Hyglone.
Important: If them 27 Is marked other than 'natural', or Neme 23a or 28a-f ahow any Injury or other traumatic event, the Medies Essentian matter in a programment of the Medies Issuerian matter and the modes.

Baitimore, Maryland 21215-0020

tehlik, Anna

Medical Certification: To Be Completed by Physician/Medical Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case rafarred to medicat examiner? 1 Yes 2 No 27. Manner of Death 2 Accident 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, larm, sfreet, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one)

0 State Registrar

To the Hosp within 24 hor To the Fune completely fi

31. Data filed (Month, Day, Year)

29b. Signature end title of certifier

Alabras 32. Registrar's Signature Geneva FEB 1 6 2000

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1 MD

30. Nama and addrass of person who completed cause of death (ttem 23a) (Type, Print)

Agora Drive, 20 Bel AIR MD 21014

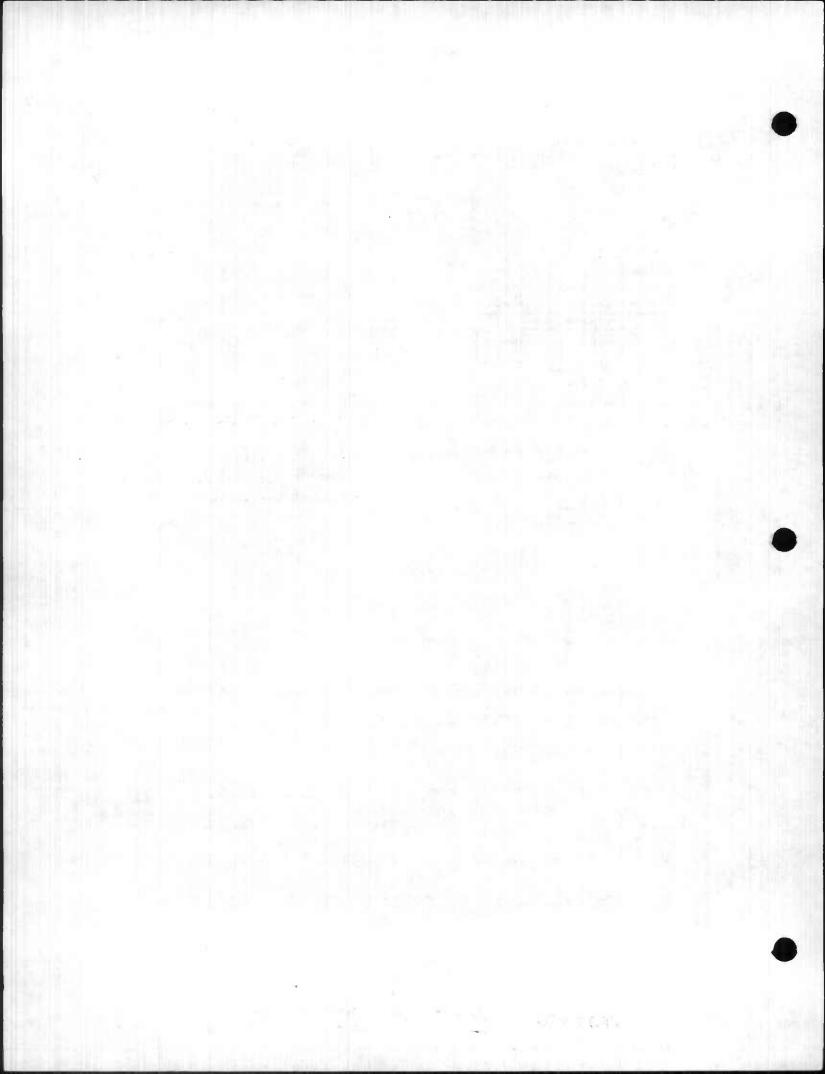
29c. License number

037612

29d. Date signed (Month, Day, Year)

Jeb 14-2000

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 11, **Physician** 9:57pm 2000 Ulvsses Toogood /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2812 Ulman Avenue Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sept 18, 1 Days 10 M 2□ F Yrs 35 1964 Maryland Director 212-82-3056 Usual Residence of Decedent the Marylan 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits **X** Yes 2 No 128e-f Director MD N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 21215 TISA Berrie 23a 2812 Ulman Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 21☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married "natural", or il adical Examin Baltimore, Maryland 21215-0020 Black 1 Yes XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72.1.

Department of Health and Mental Hygiens.

Amportant if Nem 27 is marked other than "nettal any Injury or other traumatic average than "nettal page." 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry rade completed Elementary/Secondary (0-12) 12th College (1-4or 5+) Custodian Airport 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Ernestine Smith Leonard Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2812 Ulman Avenue Baltimore, Maryland 21215 Frances E. Toogood (Mother) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/16/2000 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 21. Signature of Funeral Service Monsee 22. Name and Address of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examine physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Due to (or as a consequence of): 88 080 signed by the a P.O. Part II. Other algorithms conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of death? page 2 1 Yes 2 0 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. completely er: On the basis of exa-and manner stated. (Check only nination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) To the F 29b. Signature as 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

2000

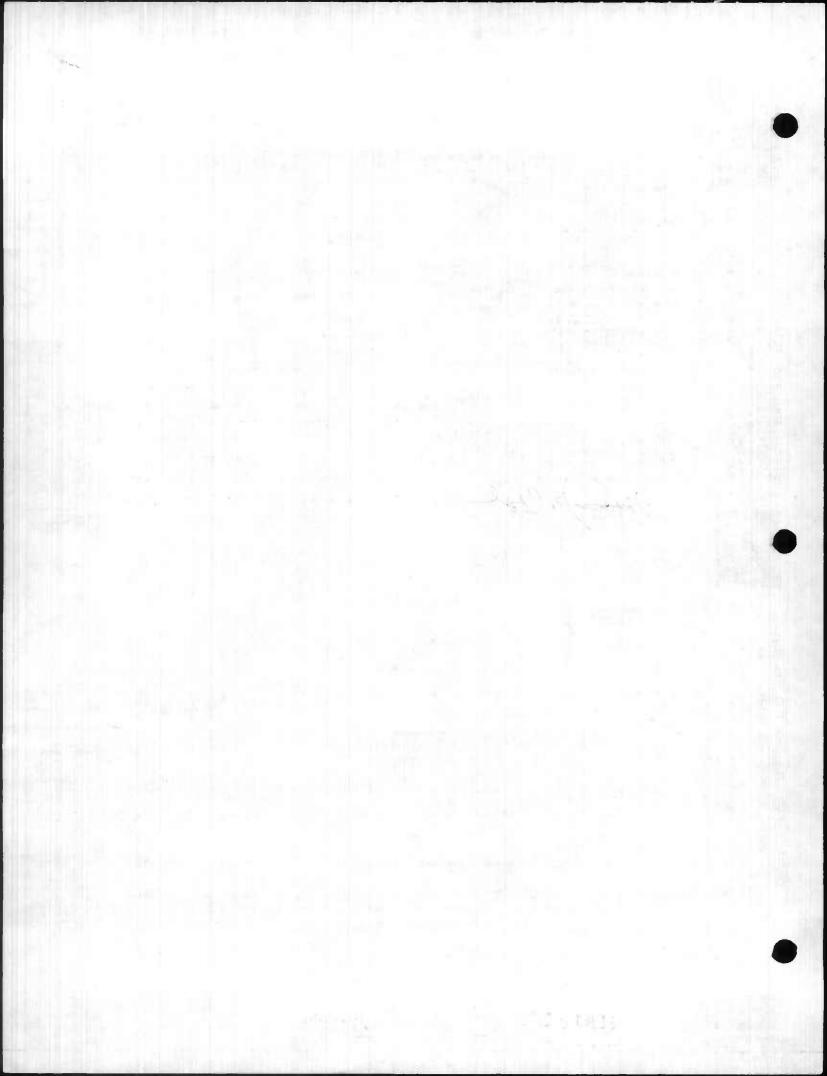
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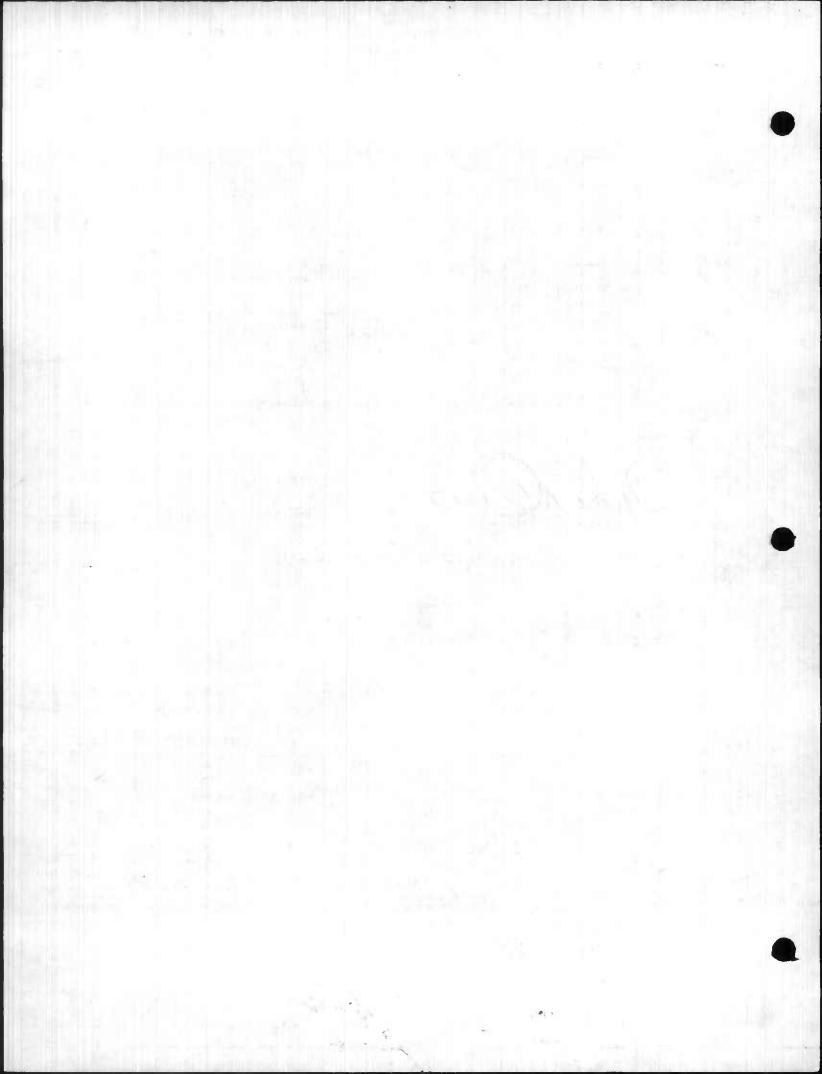
(Item 23a) (Type, Print) 600

32. Registrer's Signature



	Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible
5	State of Manuard / Department of Health and Mantal Husiana

Physician		Decedent's Name (First, Middle					Death		2. Date of Dear Month	eg. No.	Year	3. Tima of Death		
/Medical		Douglas	Clinton	The	omas				FEBRUA		2000	0229 AM		
Examiner	4a Facility Name (If not institution, give street end number) FRANKLIN SQUARE HOSPITAL ESSEX								cation of Death	4c. County BALTI				
Funeral Director	2	217-74-2485	6. Sex 1 M 2 F	Age (In yrs. 41 40	last birthday) Yrs.	Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day 02-21-	Year) -59	9. Birthpl Count M D	ace (State or Fore ry)		
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To allo		eorge		omas	I = 33			nit		Wesle	4	- MD		
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Importar any injur ansa.	21	21. Signature of uneral Service Licenses 22. Name and Address of Fecility Ba								altimore, Baltimore 21 101 E. North Avenue				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vanz Mary Jane Tender 13, Feb. 2000 3:02pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale Baltimore If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) 12-25-23 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 261-36-2946 1 M 2 F 76 GA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD J TYes 2 □ No NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1300 Windlass Drive 21220 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. 14. Rece - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6th Grade in home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Unknown Drucilla Parker 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Retetionship (Type, Print) Barbara Travis Oakgrove Drive Apt. "A" Baltimore, MD 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2x☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Cemetery 02-18-2000 Baltimore, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate intervet Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Qu mon la Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that hittated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturet 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of tnjury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steted.

P.O. Division of Vitai Records. To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

Physician

/Medical

Examiner

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Certification:

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XABO 31. Date filed (Month, Day, Year)

29b. Signeture and title of certifier

96md

certificate

After

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Registrar

2000

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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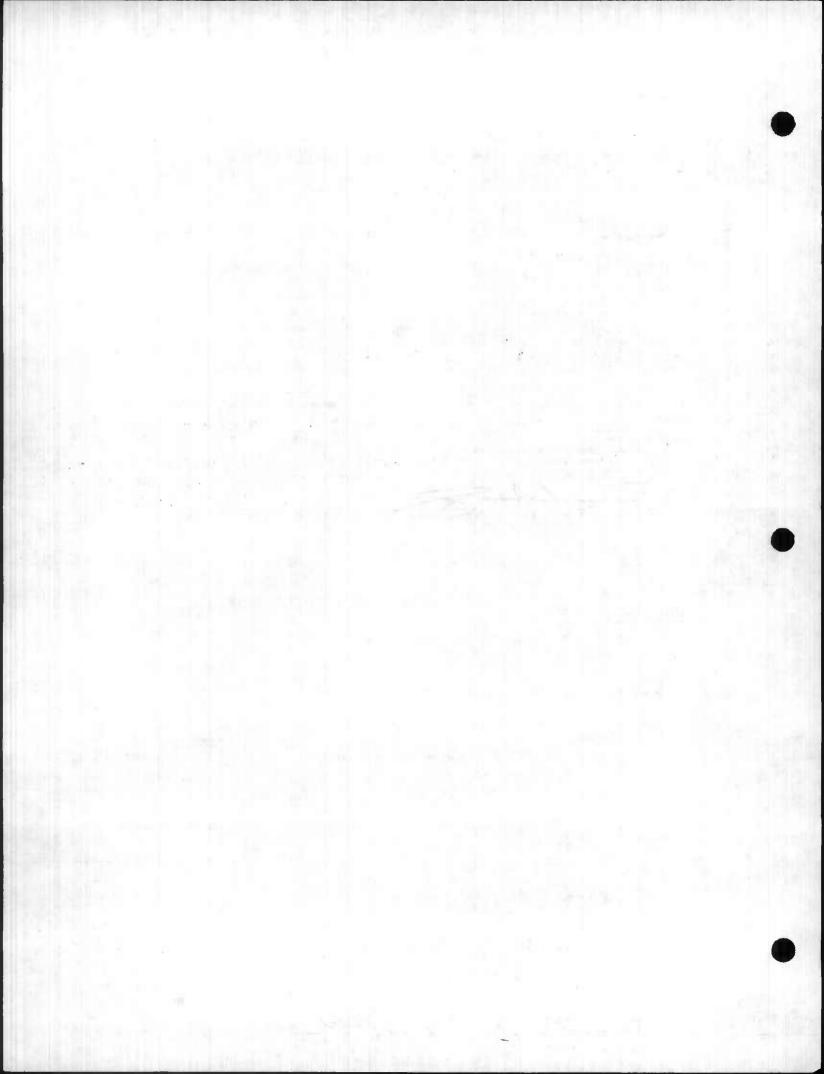
E Northern

29c. License number

Parkway Baltimore 21214

ORIGINAL

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month THOMAS HEL 2310 12 00 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Baltimore OF MARYLAND BACTIMORE INIVERS 174 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (Steta or Foreign Country) 6. Sex Months 1 M XCXF Days Hours 219-16-3884 M.D Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 15 Yes 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 2113 Division Street Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give: Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2√ No Specify: 3 ◯ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Provider Private 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Adelle Scriber Francis Scriber 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Franklin-Daughter
20m. Method of Disposition Baltimore Md 21217 1626 Booker Ct., 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2-18-00 Baltimore, Md New Cathedral Cem. 21. Signature of Fugeral Service Licenses 22. Name end Address of Fecility March F/H West 4300 Wabash Ave, Baltimore al 21215 216. Peril. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finet disease or condition resulting in death) EUKEMIA Due to (or as a consequence of): Jepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): CR1515 AST that initiated events resulting in death) Last Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1□ Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ FVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

attending physician and for use as the buriel-transit The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. 2 has page 2 After this certificate To the Hospital or Attanding Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it

Physician

Examiner

Director

Funeral

by

Completed

Be

2

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Hesith and Martiel Hygione.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show with fully or other traumatic event, the Maddel Emerical must be notified at once.

Physician

/Medical

Examiner

Saitimore, Maryland 21215-0020

/Medical

Physician/Medical by Completed Be 2 edical Certification:

Examiner

1 Tes 2 No 27. Manner of Death 1 Matural

4 ☐ Homicide

(Check only one)

29a, Certifier

6 Could not be

charl

281. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified

6

29c. License number

29d. Date signed (Month, Day, Year) 2-12-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOINICK MICHAEL

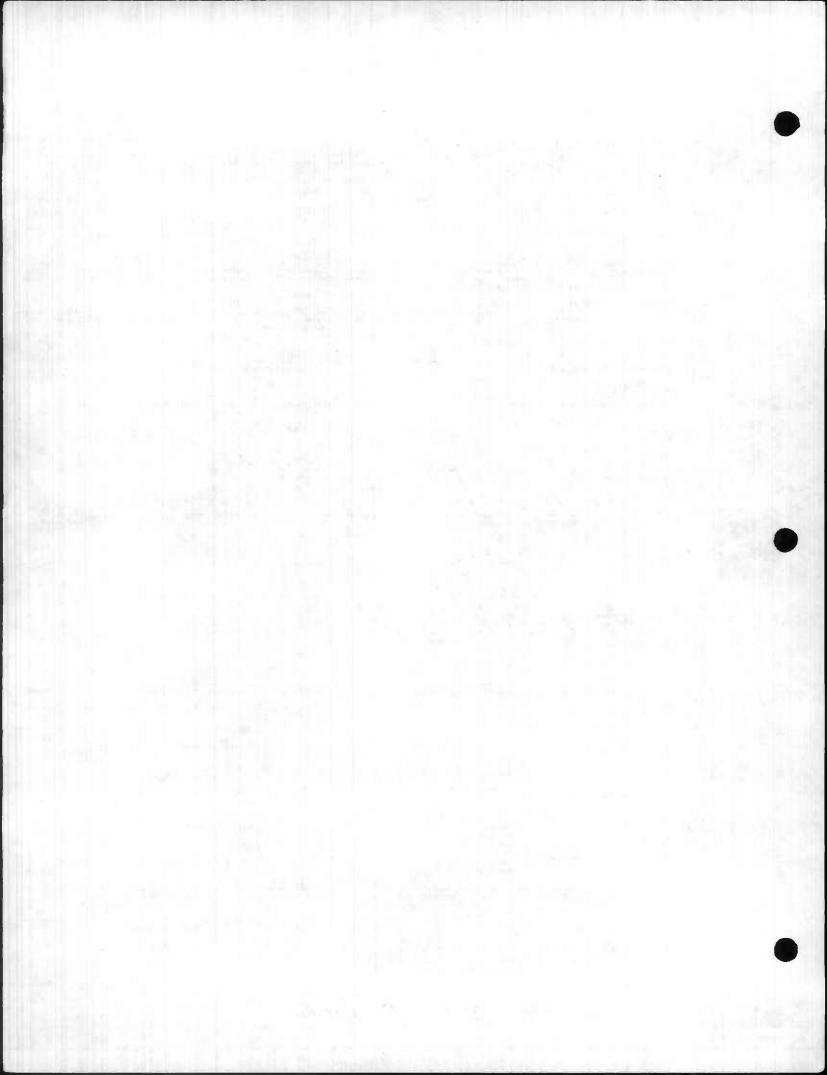
UNIVERSITY OF MARYland MediEAL Center

31. Date filed (Month, Day, Year)

32. Registrat's Signature

State Registrar

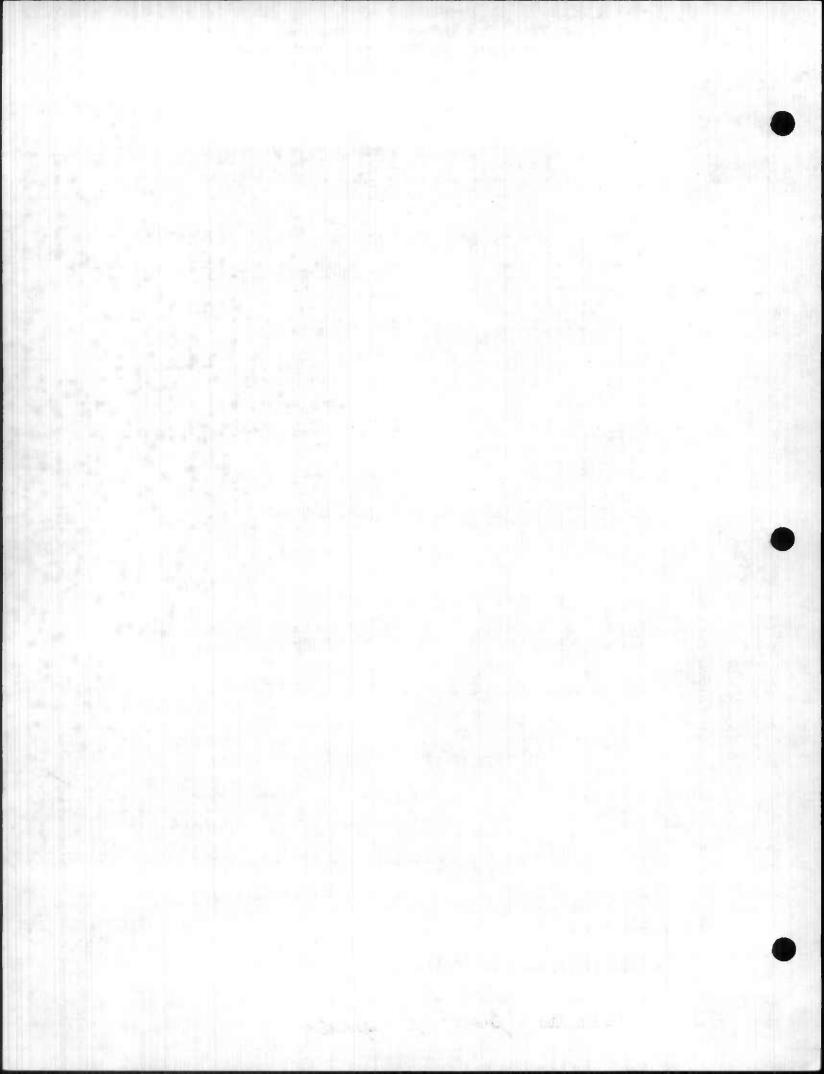
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Tima ol Death Day Month Yaar **Physician** Feb. 13, 2000 Reese A. Tasker 6:15 pm /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 129 Willow Spring Rd. Dundalk Baltimore Hours Min. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days XXM 2 F 69 Yrs. 177-24-0562 Director Nov. 22, 1930 Pa. Usual Residence of Decedant 10a Stata 10h Counts 10c. City. Town or Location 10d Inside City Limits show Md. Baltimore Dundalk 1 ☐ Yes ※ No Director 288-7 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code b must be 129 Willow Spring Rd. Borns 23a 21222 Funeral USA 12. Was Decedent Ever in U,S. 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. Armed Forcas?

1 Yas 2 No
If Yas, Giva
Yaar or Datas: Black, Whita, atc. 1 Nevar Married 2 Married ä Maryland 21215-0020 1 Yas XXNo Specify: Specify: White 3 3 Widowed 4 □ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Manager Food Store 10 yrs 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) å and Mental reportant: If Item 27 is marked Reese A. Tasker Sr. Mabel L. Ransom Pages 1 and 2 should 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Dorothy J. Taylor sister 216 Stone House Rd. Carlisle Pa. 17013 altimore, 885 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, cremetory or other place) Data 20c. Location - City or Town, Stete 1 Burial 2XX remation 3 Removal from Stata 4 Donation 5 Other (Specify) Feb. 15 2000 Metro Crematory Baltimore 22. Nama and Addrass of Facility 21. Signature of Funesal Service Licensee Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Pert / Enfar the disease, or complications that eaused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Intarvel Batween Onset and Death **Physician** /Medical Immediate Ceuse (Finel 055166 disaase or condition rasulting in death) Examiner Examiner physician and s the buriel-transit Sequentially list conditions, if any, laeding to immadiata cause. Enter Underlying Cause (Diseese or injury that initiated evants rasulting in death) Last Due to (or es a consequança of): D um BAR Box 68760 Physician/Medical Dua to (or as e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Tea 2 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy lindings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yas 2 No certificate Division of Vital Attending Physician: Be 25. Was casa ralarred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Assidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To this 28a. Deta of Injury (Month, Day Year) funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Panding death. 1 Yes 2 No invastigation 2 Accidant within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 4 Homicida 8 Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. To the within 2 29b. Signatura end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14221 2.15.200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ports are 2121 In Row. · Brown 0 Leg 123 31. Date tiled (Month, Day, Year) 32. Registrer's Signeture State Registrar 2000 **DHMH 16 Ray 6/95**

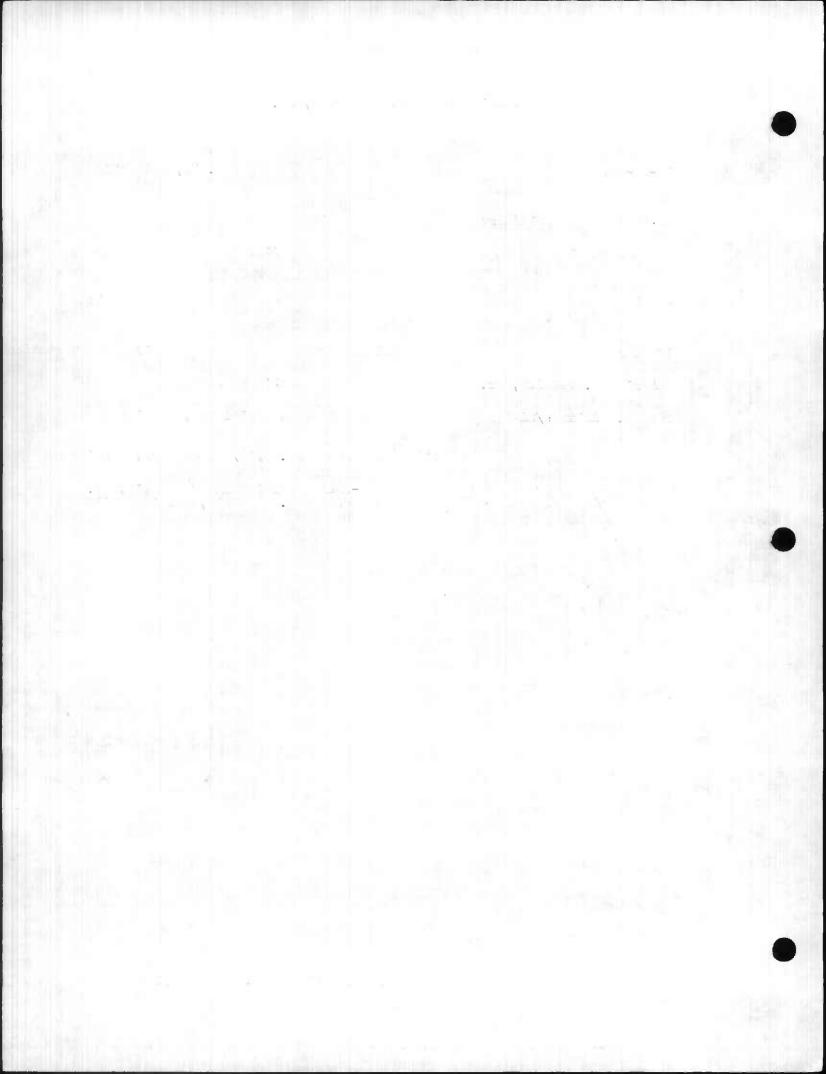
ORIGINAL



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		8006 EASTDALE	ROAD				DUNDAL		BALTI	MORE	
neral ector		Social Security Number 218-58-2551 sual Residence of Decedent	6. Sex 1⁄1 M 2□		yrs. last birti Y	hday) If Under 1 Year frs. Months Day		8. Date of B (Month, D Aug.	inth Year 1952	9. Birthplace (State or Fore Country) Onlo	
Med et	10	On. State 10b. County Maryland	Balti	1	. City, Town	or Location Dunda	alk			10d. Inside City Lim 1 ☐ Yes 2 🔯	
it, or home 23s or 25s-f s families must be notified by Funeral Director								.224	What Country? ed States		
		1. Maritaf Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 1	Decedent Ever ind Forces? Yes 28 No. 8, Giva	n U,S.	13. Was Decedent of If Yes, specify Control of Italian Yes 2018	uban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)		e - American Indian, ck, White, etc.	
			nt's Education	or Detes:	16a.	Decedent's Usual Occ	cupation		16b. Kind of Br	usiness/Industry	
Completed		(Specify only higher Elementary/Secondary (0-12) 12 Years	st grade comple	ted) ge (1-4or 5+)		(Give kind of work dor life. DO NOT use ret Taxi Cab I	ne during most of w ired)	rorking		ic Transporta	
important: if item 27 is marked other any injury or other traumatic avant, a poss. To Be Co	11/	7. Father's Name (First, Middle, Charles L. T		Sr.				ame (First, Middl een Hari	e, Maiden Suman	ne)	
	1	9a. Informant's Name/Reletions Penny L. Willi				Mailing Address (Street) 06 Eastda.					
	20	Da. Method of Disposition 1 ☐ Burial Z□Cremetion 4 ☐ Donation 5 ☐ Other (S			cemetery	Disposition (Name of y, crematory or other p cop Service		Date /15/00		City or Town, Steta , Maryland	
1000	2	1. Signature of Juneral Service	Licensee	20		22. Nama and Add		1 Home	of Dundal	lk Inc	
	2	3a. PRITI. Enter the disease, or shock, or heart failure. List	complications to	het caused the d on each line.	leath. Do n	7922 Wi	se Ave.	Dundalk	Marylar	Approximete Interval Between	
cal ner	ir d	Sa. Putt 1. Enter the disease, or shock, or heart feilure. List immediate Cause (Finel isease or condition asulting in death)		COTIC A	ND ALC	7922 Wi	Se Ave. lying, such as cardi	Dundalk	Marylar	nd 21222	
examiner Examiner	ir d	nmediate Cause (Finel isease or condition		COTIC A	ND ALC	7922 Wisot enter the mode of d	Se Ave. lying, such as cardi	Dundalk	Marylar	Approximate Interval Between	
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/Medical Examiner	Beverly 4a Facility Nama (If not institution		Ann			v	esta		2. Deta of Dea Month FEB	Day 12, 20	Year	3. Tima of Death 0537 AN
	GOOD SAMARITA		umber)				b. City, To	wn, or Li	ocation of Death			
Funeral Director	5. Social Sacurity Number 218-72-0756	6. Sex 1 □ M 2 □ F		rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under		8. Data of Birth (Month, Day	, Year)		place (Stata or Foreig Intry)
one. than "natural", or frams 23a or 28a-f ahow the Madical Examiner must be notified at ompleted by Funeral Director	Usual Rasidanca of Dacedent 10a. State 10b. County MD NA			10c. City, Town or Location Baltimore								10d. Inside City Limit
by Funeral	803 41st Str 11. Marital Status 1 XNevar Married 2 Ma 3 Widowed 4 Divorce	12. Was Dec Armed F mied 1 Yes	2 X No liva Dates:	16a Dece	1 □ Yas :	dent of Hi cify Cuba 2) No	Specify:		ecify Yas or No- Rican, atc.)		ck, Whita,	can Indian, , atc. Lack
Be Completed	Elamentary/Secondary (0-12)	College	(1-4or 5+)		er-L							cy Glass
	17. Fathar's Nama (First, Middla Warren Vesta					Mary	Mi	a (First, Middle, tchell				
er treum	19a. tnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Commany Vesta-Mother 1935 E. Belvedere Ave, Baltimore Mother											
once. To	20a. Method of Disposition 1 ☒ Buriai 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3		Stata	Plece of Dispo comatary, cres	natory or o	ther plac	•	2		20c. Location		own, State

Physician /Medical **Examiner**

The law requires that the death certificete be executed

s been signed by the should be detach

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, in

þ

Completed

Medical Certification: To Be

Division of Vital Records, P.O. Box 68760,

Examiner the ettending physician and hed for use as the buriel-transit Sequantially list conditions, if any, laeding to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated avents rasulting in death) Last Physician/Medical

Immedieta Causa (Final diseasa or condition rasulting in death)

INTRACEREBRAL HEMORRHAGE

Due to (or as a consequence of):

VEGETATION EMBOLIZATION

Dua to (or as a consequence of):

ENDOCARDITIS

Dua to (or as a consequence of):

Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

FEB.

24b. Were autopsy tindings available prior to completion of cause of death?

Yes 2 No Yes 2 No

12, 2000

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20ER/Outpatient 3□ DOA

Hospital: 1 ☐ Inpatiant 28c. Injury at Work? 28d. Describe how injury occurred

28a. Data of Injury (Month, Day Year) 1 Yas 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

XX Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifian (Check only 29b. Signatura and titla of Certifiar 29c. License number 29d. Data signed (Month, Day, Year)

and address of parson who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

O.C.M.E

31. Data filed (Month, Day, Year)

FEB 1

25. Was casa referred to medical axaminar?

5 Panding invastigation

6 Could not be datarmined

XX Yes 2 No

27. Manner of Death

1 Netural

2 Accidant

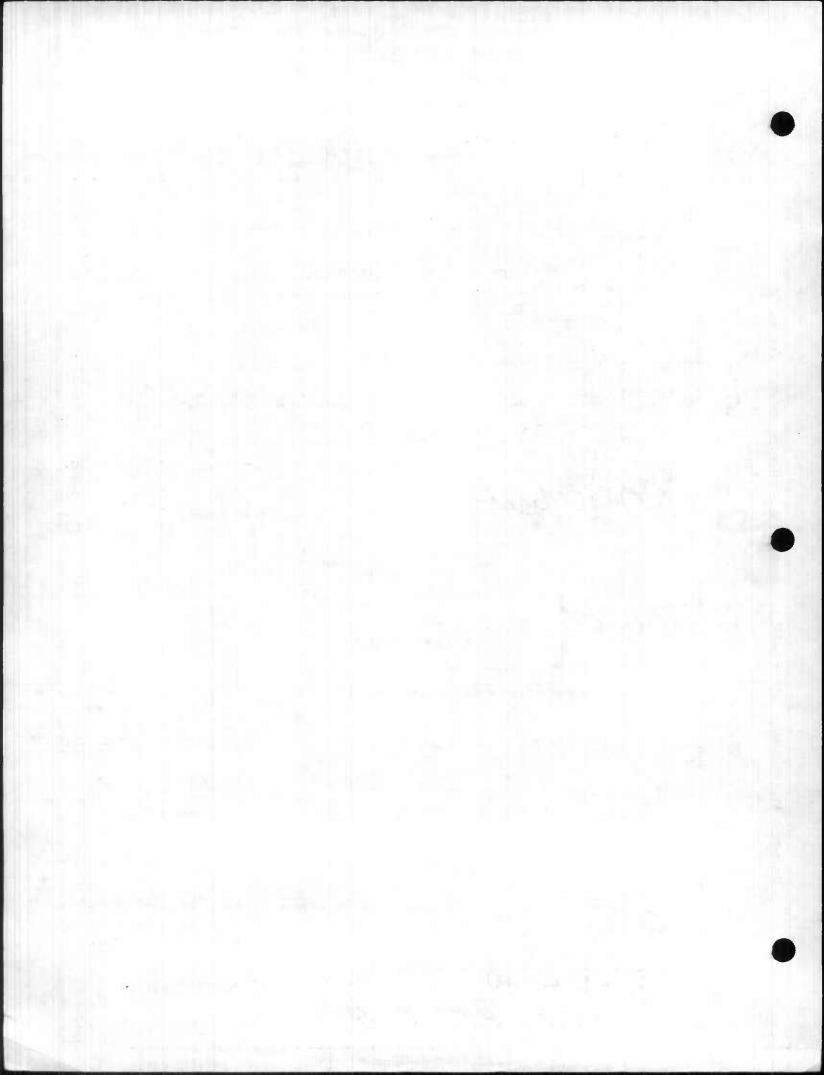
4 Homicide

3 Suicide

32. Registrar's Signatura

State Registrar

DHMH 16 Rav 6/95



Funeral

Director

Norre 23s or 28s-f show

Pages 1 and 2 should be nent of Health and Mental.

or other traum

Physician

/Medical

burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible		Please Type or	Print In Blac	ck Indelible ink.	Assure All	Coples	Are Legib	le
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Year **Physician** DEVIN LANEY WILLIAMS 30 A.M. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CENTRR BALTIMICE FRANKLIN SOUARE HOSPITAL ROSEDALE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Deys Hours 180 M 2□ F N/A FEB. 11, 2000 MARYLAND 51 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No MARYLAND BALTIMORE **OVERLEA** Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21206 5626 NORTH LANE U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 Yas 2 No
If Yes, Give
Year or Detes: 1X Never Married 2 Merried 1 Yea 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Busineas/Industry Elementery/Secondary (0-12) College (1-4or 5+) INFANT TNFANT N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be DENNIS CAROL LANEY MARY ZELPHA DEBBIS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addreaa (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5626 NORTH LANE, BALTIMORE, MARYLAND 21206 MARY ZELPHA WILLIAMS (MOTHER) 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Stete 2/17/ 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK GLEN BURNIE, MD. 2000 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 21. Signeture of Funeral Service Licensee 23a. Pert1. Enter the disease, or complication, that saused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one care on each line. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Approximate Interval Between Onset and Death a. IMMATURITY

Due to (or as a consequence of):

b. CHORIOAMNIONITIS

Due to (or as a consequence of): Immediate Cause (Finel diseasa or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last PRETERN LABOR

Due to (or ea a consequence of): Physician/Medical PRETERN PRENATULE RUPTULE OF MENBRANE Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wea an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 annatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2D No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 Yas 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, lerm, street, tectory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier Medical 1 Cortifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Dete signed (Month, Day, Year) 29b. Signeture and the of certifier RD 198986 30. Name and address of person who completed cauce of death (Item 23a) (Type, Print)

State Registrar

certificate

this

After

death.

24 hours efter deat Funeral Director:

within 2 \$

Hospital

funeral director.

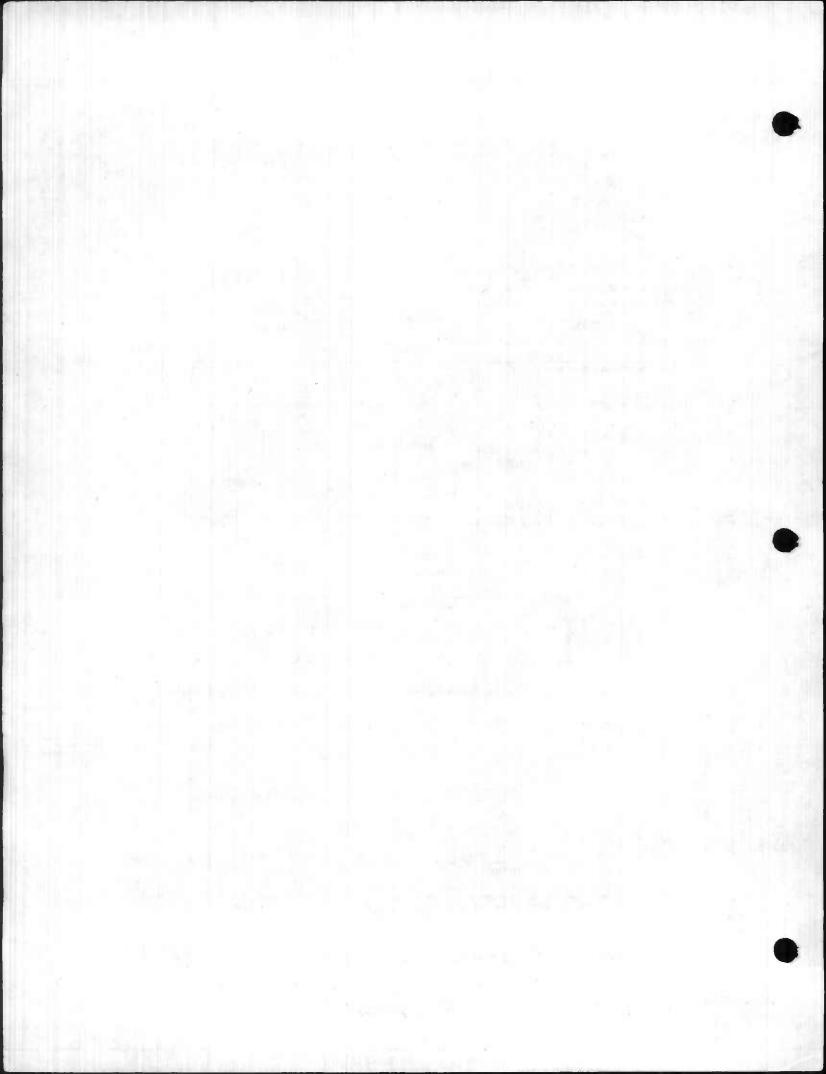
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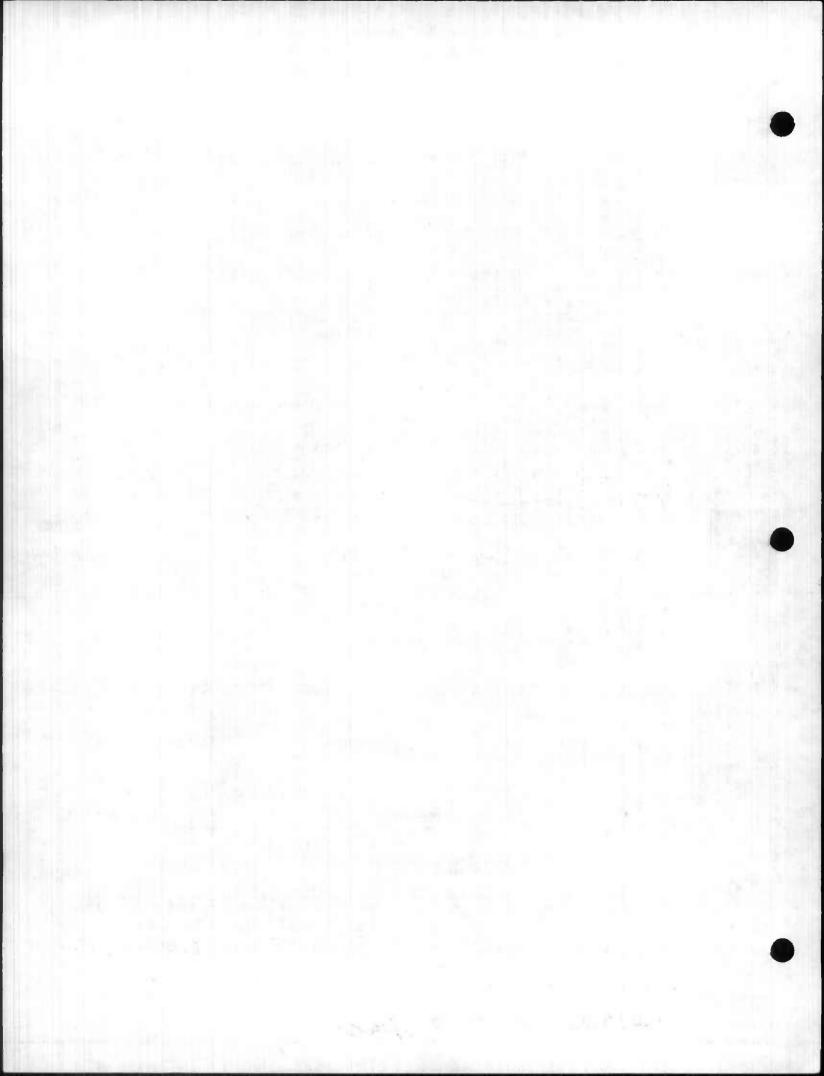
SQUARE DR. BALTO, ND

9000 FRAMZLIN

32 Begistrar's Signature



State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vasi **Physician** LESLIE 6:30 PM WHILDEN FEBRUARY 14, 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 959 SCHOOL LANE GAMBRILLS ANNE ARUNDEL If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days ₩ 2□ F 155-05-8343 78 MAY 21, 1921 Director NEW JERSEY Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Directo ANNE ARUNDET. GAMBRILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 959 SCHOOL LANE Berns 23a 21054 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritel Stetus Black, White, etc. shar 1 XYes 2 No If Yes, Give Yeer or Detes:43-54 1 ☐ Never Married 2 ☑ Merried Baltimore, Maryland 21215-0020 "natural", or 1 Tyes 2 No Specify: Specify: WHITE þ 72 hours 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. UNITED STATES Elementery/Secondery (0-12) College (1-4or 5+) GOVERNMENT 10 PAINTER - FOREMAN permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If them 27 is marked other any injury or other treametic event. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MURPHY WHILDEN MABEL HACKET 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 959 SCHOOL LANE, GAMBRILLS, MD 21054 EDITH DOROTHY WHILDEN (WIFE) 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State FEB 18 2000 MARYLAND VETERANS CROWNSVILLE, MD 21. Signature of Fundal-Serv 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23e/Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) ances 6 Month Examiner Due to or as a consequence of): Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Due to for as a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 9 1 Yes 2 No this 27. Menne of Death 1 Netural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: i or Attending P After 5 Panding investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) n 24 hours after ne Funeral Direct pletely filled in b 4 Homicide the Hospital edicai 29a. Certifier 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. within 24 hox To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steled. 29b. Signeture and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) on M.D D39505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) they Glen Burne, MD. 21061 udhish 1600 crain Markan Dete filed (Month, Dey, Year) 32. Registrar's Signature State Registrar 6 2000 Sparks



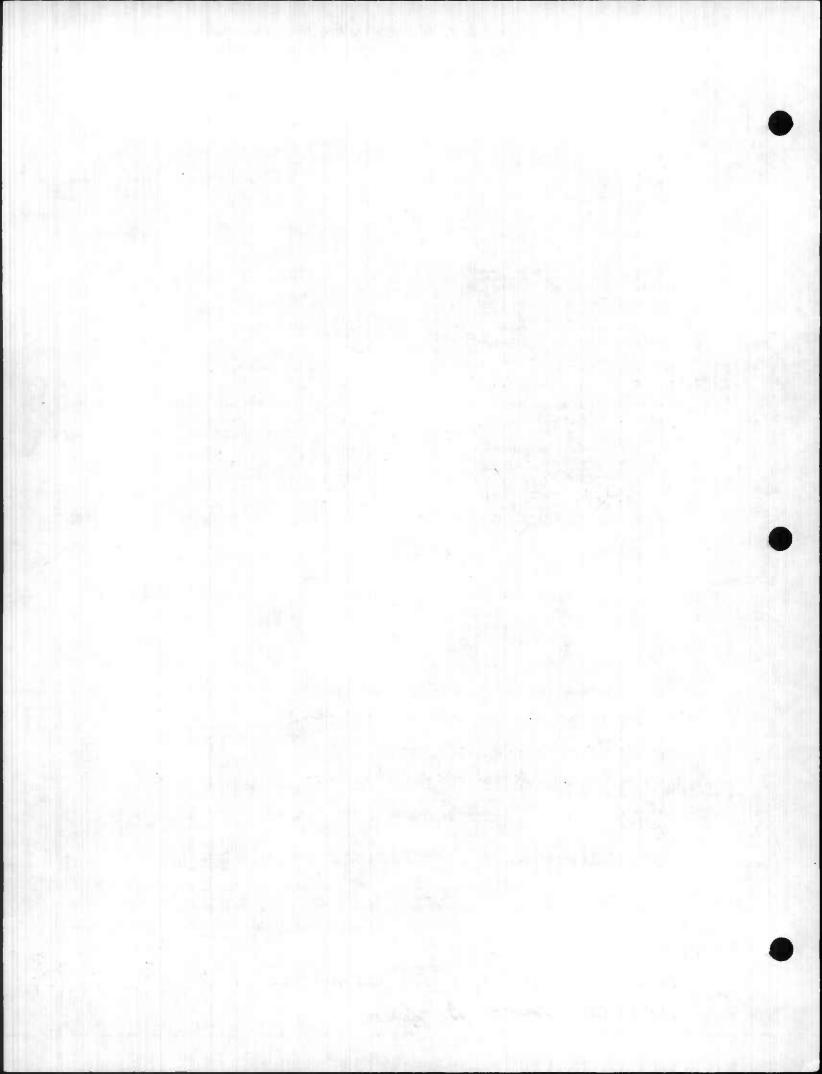
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 75,2000 **Physician** February 4:45PM Wright Leslie Daniel /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mariner Health Of Glen Burnie Glen Burnie 8. Data of Birth (Month, Day, Year) Alig. 13,1915 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1⊠M 2□ F Michigan Director 382-10-3949 84 Usual Rasidence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Maryland Anne Arundel Pasadena 1 Yas 2 No Director 10f. Zip Code 21122 10e. Street and Number 10g. Citizen of What Country? 8 8113 Ventnor Road USA Rema 23a death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If New 27 is marked other than "natural!" or language or other traumatic expenses. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: p 43-45 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker Construction 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) L. Manning Minerva Leslie Wright 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ventnor Road Pasadena, MD 21122 8113 Marietta H. Cutter /daughter 20a. Method of Disposition 20b. Piace of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/16/2000 Baltimore, MD Metro Crematory, Inc 21. Signature of Funeral-Service County 22. Name and Address of Facility
Stallings Funeral Home P.A. 3111 Mountain Road Pasadena, 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician at the burial Box 68760. Physician/Medicai Due to (or as a consequance of) US0 85 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. dehydration, 1 Yaa 2 No 3 Probably 4 Unknown þ 24e. Was en autopsy performed? 24b. Were autopsy findings available prior to Be Completed completion of cause of death? tea ons 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical axaminer?

1 Yes 2 No 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospitel: edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3D DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 2 Accident 1 Yes 2 No 24 hours after death. Funerel Director: A Investigation 6 Could not be 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner as stated.

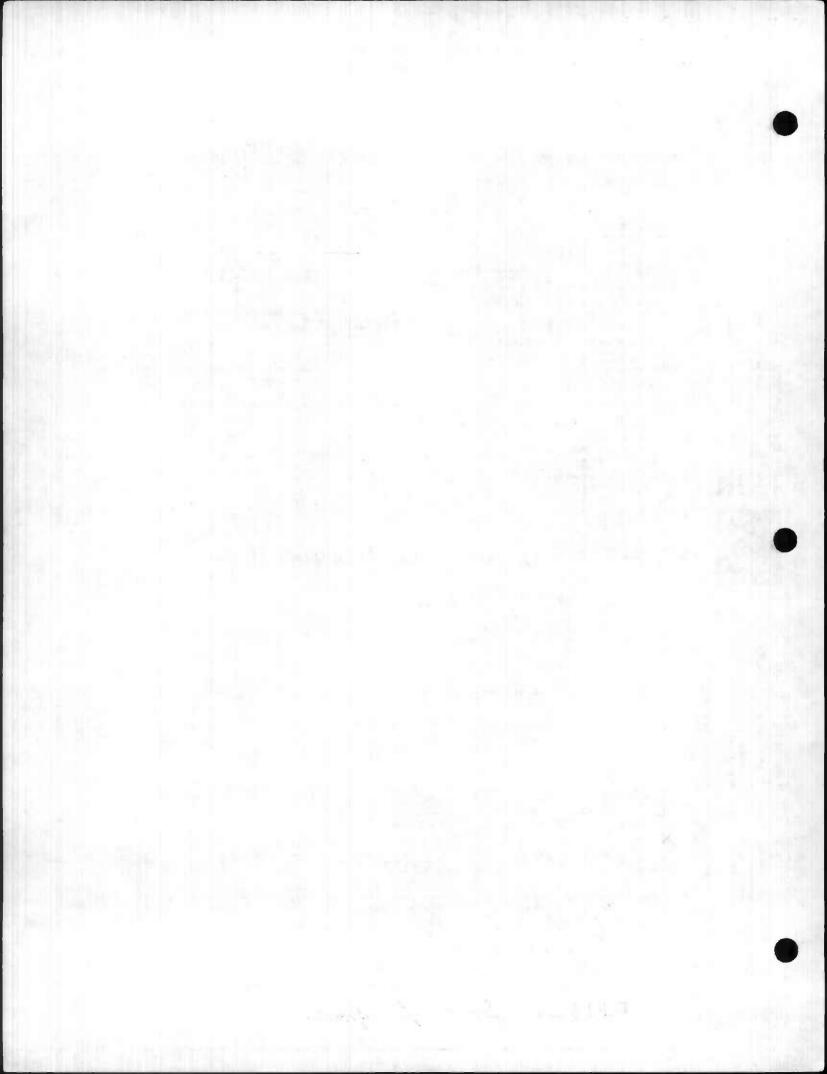
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar stated. (Check only one) To the Within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Cabel FEB 1 6 2000

DHMH 16 Ray 6/95

State Registrar 32. Registrar's Signature



	ITEM #10f PER FH G780 2/16/2000 AH Certificate of Death 1. Decedent's Nema (First, Middle, Last)								U4(Tima of Death							
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			10c. C	ity, Town or Lo	cation				10d.	Inside City Limits							
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0e. Street and Number					10f. Zip Code	(a)		10g. Citizen of	What Country?								
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	o control Cit) [0	4.		11.			set and Death							
disease or condition			atec	a	dion	140 pas	my		1								
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art II. Other significant conc	litions co	ntributing to de	eath but not ra	sulting in the un	derlying causa	given in Part I.	23b. Did	tobacco use c	ontribute to the	cause of death?							
							10	Yes 2 No	3 Probabl	y 4 Unknown							
							24a Was	an autopsy	24b. Were a	autopsy findings							
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							Z)kt	24a. Was an autopsy performed? 24b. Were autopsy available prior completion of death? ★文字s 2 No 1文字s 2 25. Wes case referred to medical 26. Place of Death (Check only one)									
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5 AUT I I I I I I I I I I I I I I I I I I I	NORTHWEST HC S. Social Security Number 215-46-8863 Susaf Residence of Decedent 10a. State MD 10b. Con BAL 10c. Street and Number 4 ROYALT 11. Marital Status 17. Never Married 2 13 3 Widowed 4 Divor 15. Dece (Specify only his Elementary/Secondary (0-1 12th 17. Father's Nama (First, Mick Eccleston 19a. Informant's Neme/Retati Steven Wain 20a. Method of Disposition 10 Buriat 2 Cremati 4 Donation 5 Other 21. Scharling of Funeral Serv 22a. Part Enfer the changes shock, or heart failure. Immediate Causa (Finat disease or conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	NORTHWEST HOSPITA S. Social Security Number 215-46-8863 Usual Residence of Decedent 10a. State MD BALTIMO 10b. County MD BALTIMO 10c. Street and Number 4 ROYALTY CO 11. Marital Status 17. Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grace Elementary/Secondary (0-12) 12th 17. Father's Nama (First, Middla, Last) ECCLESTON W. W. 19a. Informant's Neme/Ratationship (T. Steven Wainwrig 20a. Method of Disposition 10 Buriat 2 Cremation 3 In 10 Buriat 2 Cremation 3 In 10 Buriat 2 Cremation 3 In 11 Steven Wainwrig 21 Steven Wainwrig 22 Part Enter Underlying 23 Part Enter Underlying 24 Cause (Disease or conditions, if any, leading to immediate cause. Enter Underlying 25 Cause (Disease or injury that initiated events resulting in death) Last	NORTHWEST HOSPITAL CENTS. Social Security Number 5. Social Security Number 6. Sex 215-46-8863 10M 22F 215-46-8863 10M 22F 11M 22F 11M 22F 12Married Fill Security 11Marrial Status 12Married Fill Security 11Marrial Status 13Media Country 14Media Causa (First, Middla, Last) 15Media Causa (First, Middla, Last) 15Med	NORTHWEST HOSPITAL CENTER 5. Social Security Number 6. Sex 215-46-8863 Usuaf Residence of Decedent 10a. Stata 10b. County MD BALTIMORE 11. Marital Status 12. Was Decedent Ever in the Armed Forcas? 11. Marital Status 12. Was Decedent Ever in the Armed Forcas? 13. Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) 12. th 17. Father's Nama (First, Middla, Last) ECCLeston W. Wainwright 19a. Informant's Neme/Ratationship (Type, Print) Steven Wainwright — Bro. 20a. Method of Disposition 10a. Method of Disposition 10b. County 11	NORTHWEST HOSPITAL CENTER 5. Social Security Number 215-46-8863 10	NORTHWEST HOSPITAL CENTER 5. Social Security Number 6. Sex 215-46-8863 1 M 2 F 54 Yrs. 215-46-8863 1 Usual Residence of Decedent 10a. State 10b. County BALTIMORE 10c. City, Town or Location OWINGS, MILLS 10c. Street and Number 4 ROYALTY COURT 11. Marital Status 11/2 Never Married 1 Usual Residence of Decedent 10c. Street and Number 4 ROYALTY COURT 11. Marital Status 11/2 Never Married 1 Usual Residence of Decedent Ever in U.S. 11/2 Never Married 1 Usual Residence of Decedent Ever in U.S. 1 Usual Residence of Security Only highest grade completed of Usual Residence of Security Only highest grade completed of Usual Residence of Security Only highest grade completed of Usual Residence of Security Only highest grade completed of Usual Residence of Security Only highest grade completed of Usual Residence of Security Only highest grade completed of Usual Residence of Security Only highest grade completed of Usual Residence of Security Only highest grade completed of Usual Residence of Security Security Residence of Security Security Residence of Security Residence	Ab. City, Town, or NORTHWEST HOSPITAL CENTER 5. Social Security Number 6. Sex 215-46-8863 1	Second Security Number 4b. City, Town, or Location of Deeders 10m 2V 54 10m 2V 10m 2	Security Number 4b. City, Town, or Location of Death Ab. City, Town, or Location Ab. City, Town or Location Ab. City	Second Security Number Security Number							

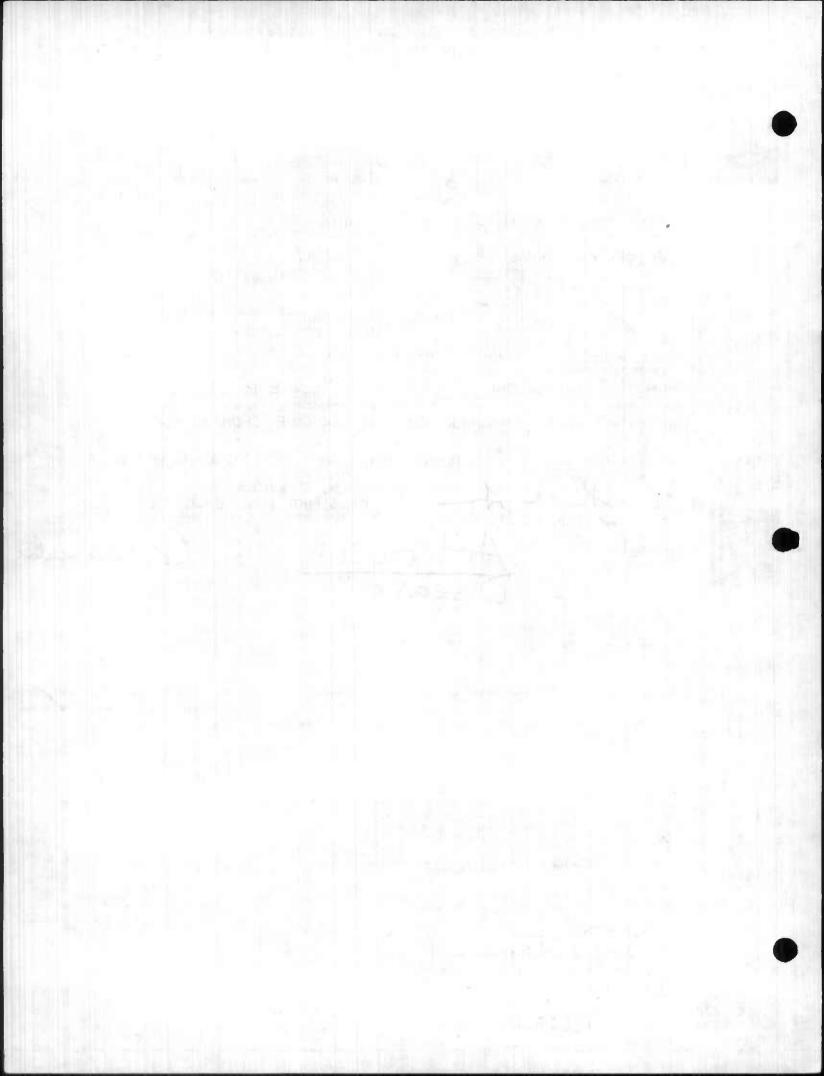


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and Mental Hygiene 04865

				Ce	rtificate	Of L	Jeath		Re	eg. No.		000	
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Ex	aminer	4a Facility Nama (If not Institution, g 2031 Bt	rooks Drive # 3	15		D	istri	ct He	eights	1	ce Ge	orge's	
Fun Dire			Sax/ 1 M 2 F 7. Age (In yrs. 59	last birthday) Yrs.	If Under 1 Months	Year Days	If Under: Hours	Min. 8	B. Data of Birth (Month, Day, 09-01-	Year)	9. Birthp Coun	place (Stata or Foreintry)	
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should ind Men	To	19a. Informant's Name/Ralationship		19h Maiti	no Address (COUS!		State Zin	Code	
and 2 sealth ar	Trans.	KIM WITHERSPOO		103		DAK			DAR CR		TX 1	8612	
-I	retto	20e. Mathod of Disposition	20b. F	Place of Dispo	osition (Name matory or other	of				20c. Location	City or To	wn, Stata	
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part.	를	21. Signature of Funerel Service Lice		22	2. Nama and	Addras	s of Facility	у		011210	1110		
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_		23a. Pert1. Enter Ille disease, or cor shock, or hear failure. List only	nplications that caused the deat		lar the moda	of dying	, such as	cardiac or r	raspiratory arra			Approximate Interval Between	
Physic	ian	Shoot, of hour man can on	A I			0		1.		1	A !	Onset and Death	
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and	Xan	Sequentially list conditions, it any, leading to immediate causa. Enter Underlying Cause (Disease or Injury	Due to (or as a consequence of): C								1		
certificate be executed iding physician and	burie	causa. Entar Underlying Cause (Disease or Injury that initiated events									i		
ficata phy:	Medical	resulting in death) Last	Dua to (o	quence of):									
	nose a		dcontributing to death but not resulting in the underlying couse given in Part f.										
death e atten	etached for u	Part II. Other aignificant conditions							23h. Did to	bacco use co	ntributa to	the cause of skal	
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		27. Mannar of Death 1 Selatural 5 □ Panding	28a. Dete of Injury (Month, Day Year)	28b. Time o	280	. Injury Work	at ?	28	d. Describe ho	w Injury occur	rred		
Attending or deeth. actor: After	the fu	2 Accidant Invastigetic			М		/es 2 □!	No					
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oltal ours a praid	2												
Hospital 24 hours Funeral	pletely fi	29a. Certifier (Check only) One) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.											
To the Hospital o within 24 hours at To the Funeral Di	Med	29b. Signatura and titla of Cartifier	and manner stated.		29c. 1	icense	number		25	9d. Data signe	d (Month.	Day, Year)	
¥ ₹ ¥	2	Par	Tanas	MI									
X		30 Name 1	The same of the sa	2201 (7		J.C.	M.E.			rebru	ary	10, 2000	
3		30. Name and address of person who	completed causa of death (Men			n Si	treet	Ral	timore	Maryl	and a	21201	
	State	31. Date field (Month, Day, Year)	32. Registrar's Signa		/	/	/	, 10th.	CHINE	ricity	LINA A	- ALV I	
	State				ALA	- 4	00 W	. /					

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Physicia	n	t's Neme (First, Middle,		James	Wanne	er, Sr.		Month	Dey	Year	6:25am	
/Medica Examine	4a Facility		give street and number)				4b. City, Town, or FORT HOT		4c. County	of Death	- C-	
Funeral Director	5. Sociai Se 502-3	curity Number	5. Sex 7. Age	(In yrs. last bit		If Under 1 Year Months Deys		(Month, Day	h		e CO. e (State or Foreign	
how how	10a. State	dence of Decedent 10b. County		10c. City, Tow	n or Loca	tion				10d.	Inside City Limits	
death with the Maryland rms 23s or 28s-f show Ernset be notified at	Maryl 10e. Street	and Ba	ltimore			10f. Zip Code	Dunda		10g. Citizen of V	What Country	1 ☐ Yes 2 (121 No	
23a o		l Bear Rido	e Road Apt	. 2			21222		United	State	es	
3 22 2		Status or Married 2 Merrie lowed 4 Divorced	12. Was Decedent I Armed Forces? d 12 Yes 2 1 N If Yes, Give Yeer or Dates:	lo		s Decedent of es, specify Cut	Hispanic Origin? (Span, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	pecify Yes or No- Prican, etc.) 14. Race - America Black, White, 6 Specify: Whi			
within 72 hours ans. than "natural" he Medical Ex	Detelo	15. Decedent's (Specify only highest ry/Secondary (0-12)	Education	16a	(Give kin life. DO	NOT use retire	duning most of wo	rking	16b. Kind of Bu		ss/Industry	
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should nd Men merks umerks		ant's Name/Relationshi		191	n. Mailing	Address /Stree	Anı t and Number or Ri	na Freita		State Zin Co	ode)	
		Michael War					dge Road					
sermit. Pages 1 ar Department of Heal Important: If Item 2 any Injury or other 2558.	1 🖾 Bu	d of Disposition rial 2 ☐ Cremation : nation 5 ☐ Other (Spe	□ Removel from State scify)	cemete	ry, cremat	ion (Name of tory or other pla Forest	V.A. Cem	Date 2/14/0	20c. Location -			
parmit. Departri Importa any inju	21. Signatu	horny Lle					Funeral Ave. Di					
Physician /Medical Examiner	Immediate disease or resulting in	, or heart failure. List o Cause (Final condition	a	the death. Do le. ATIC SQL Due to (or as a	UO! (AL)	S CARC		c or respiratory ar	rest,	In O	pproximate terval Between nset and Death	
seth certificate be executed attending physician and for use as the burial-transit		y list conditions, ng to immediate er Underlying ease or Injury d events	b	Due to (or es e								
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nysician: The law his certificate has to director, page 2 and To Re Commit			· · · · · · · · · · · · · · · · · · ·					101	res 20 No	101	res 2□ No	
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the side		of Death uraf 5 ☐ Pending ident investiga		y 28b.	Time of Injury	28c. Inju	4 U Nursing I	dome 5 ☐ Resident 28d. Describe t	now injury occur			
Ital or Attending Physical Section 11 and 12 and 12 and 12 and 13		dotormin	28e. Place of Injubulding, etc		erm, street	t, factory, offica		28f. Location (5 City or Tox	Street and Numb vn, State)	per or Rural R	oute Number,	
To the Hospital within 24 hours a To the Funeral Completely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the time, date and place, and due to the death occurred at the dea								cause(s) and ma date and place,	anner as state and due to th	ed. e cause(s)	
To the within To the comple	29b. Signati	ore end title of certifier	6. Cm	4.lm	^	29c. Licen	se number		29d. Date signe	d (Month, Da	y, Year)	
· LX	-		no completed cause of de	eath (Item 23a)	(Type, Pri					-0 /		

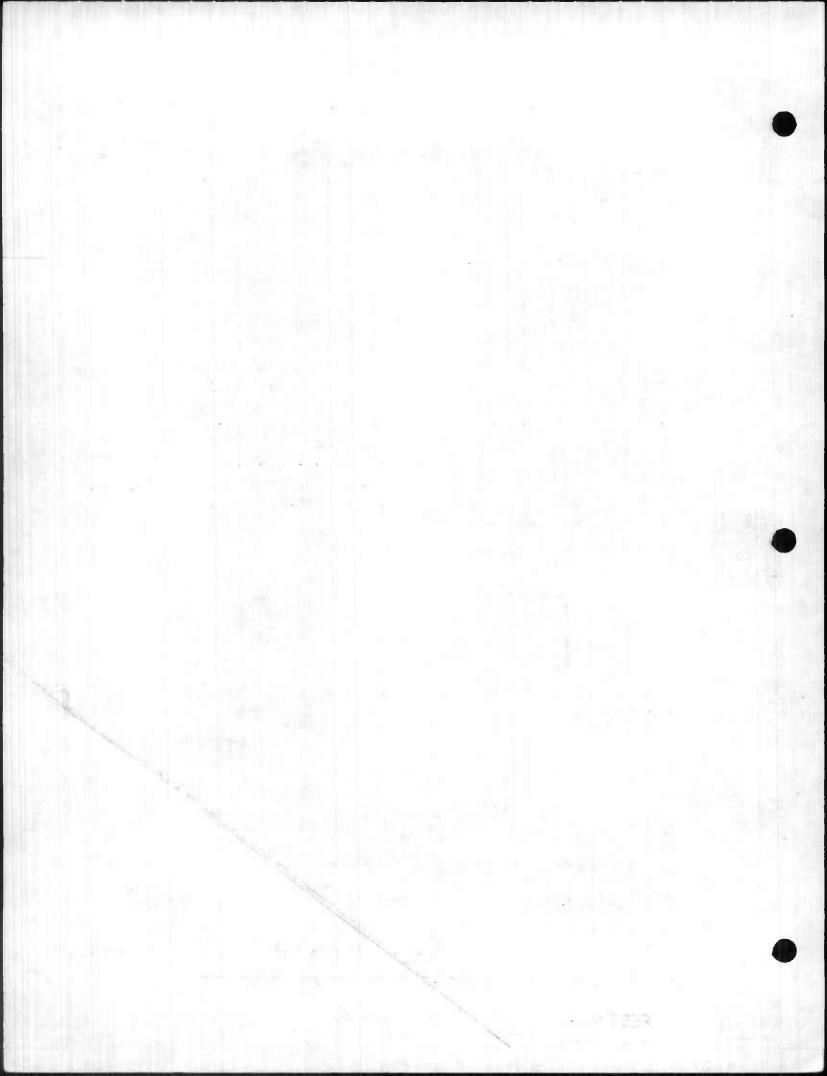
Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year) 6 2000

32. Registrar's Signature

CAROLINA C. CUSTODIO, ID FORT HOWARD VA MARYLAND HEALIN CARE.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 3. Tima of Death 2. Data of Death Day RUTH WALTO 9 2000 3:25 PM February 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A HOPKINS Bayview Johns If Under 24 Hrs. If Under 1 Yaar 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Nov. 14,1923 Days Hours Months 1 □ M 2 🖸 F 219-38-9483 76 Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas XX No Baltimore Dundalk Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 2004 Denbury Road 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Never Married 2 T Married 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Years Homemaker 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Willard Cole Essie Roupe 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) 21236 Mr. Russell Walto (Son) 9207 Ramblebrook Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata P⊠Burial 2 ☐ Cramation 3 ☐ Removal from Stata Sacred Heart of Jesus Cemi. 2/12/00 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Intarval Betwe Onset and Death Immediate Causa (Final disease or condition resulting in death) Sepsis 48 hours Dua to (or es e consequence of): Dua to (or as a consequance of): Part tl. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Cardiomyopat 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 1 ☐ Yas 2 ☐ No (Check only one)

Physician /Medical Examiner

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Certification: To

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Box 68760,

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be litted in Department of Health and Mental Hygien Important; if them 27 is marked other the any Injury or other free

Directo

Funeral

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72 hours after

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last Physician/Medical þ Completed

a 5 ☐ Rasidence 6 ☐ Other (Specify) 3d. Describe how injury occurred

25	. Was casa rafarre								26.	Place of De	eath (
	exeminar?	lo	Hospita	l: 1 Inpatient	2	ER/Outpatient	3□	DOA	Other: 4	☐ Nursing	Homa
	Menner of Death Menner of Death Menner of Death	5 Pending invastigation	28a	Data of Injury (Month, Dey Y		28b. Time of Injury	М	28c.	Injury at Work? 1 Yas	2 🗆 No	28
	3 ☐ Suicida 4 ☐ Homicida	6 Could not be determined	28a	Plece of tnjury building, etc. (- At h	oma, farm, stree	t, faci	ory, o	ffice		28

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

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ying Physician: To tha best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. at Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and mannar stated.

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29d. Data signed (Month, Day, Year) 2000

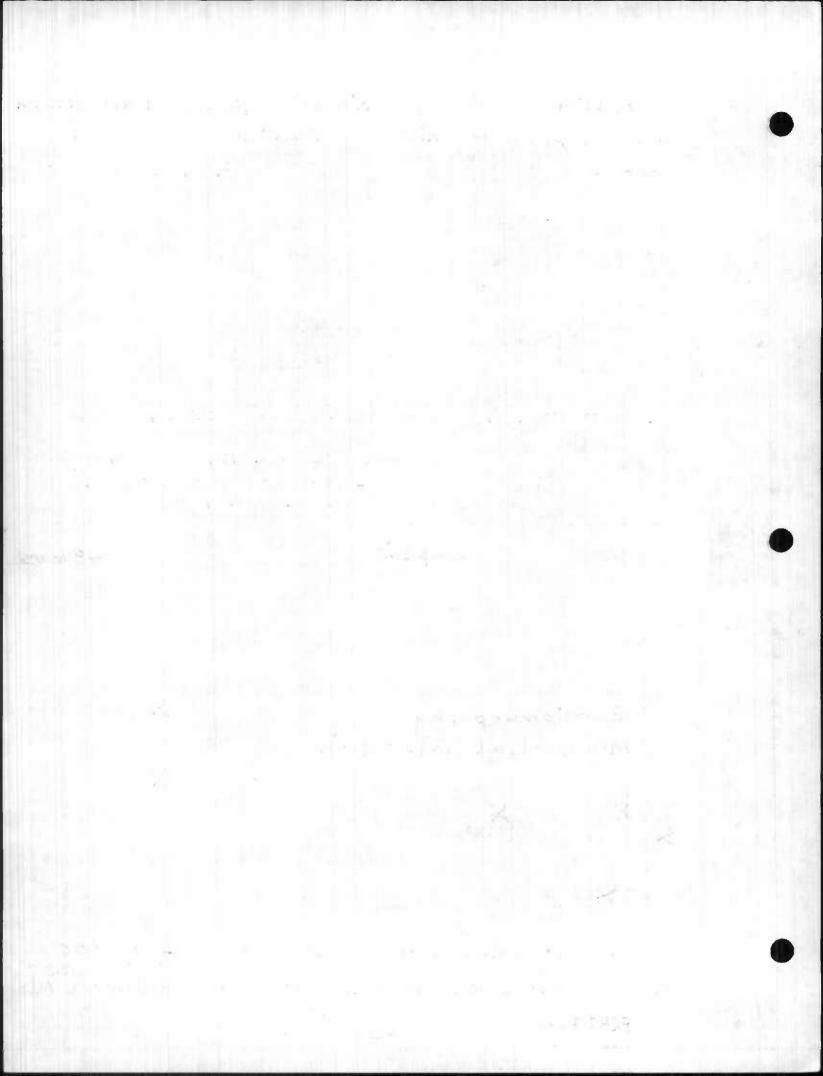
e Print)

600 N. Wolfe

State Registrar

FEB16 2000





Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month FEBRUARY 13, 2000 2:15 AM Ruth A. Wolle 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Yel March 2, 19 If Under 1 Year | If Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours MD. 1 □ M 2 🖫 F Yrs. 83 216-05-7191 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? USA 21212 722 Regester Ave. 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. 1 t. Merital Status 1 Yes 2 No if Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify 3€ Widowed 4 Divorced USA 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Alice C. Schaeffer Harry A. Bruhlman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 722 Regester Ave. Towson, MD. 21212 Jane Nolte (daughter) 20b. Place of Disposition (Name of cometery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removel from State 2/16/2000 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 2t. Signature of Funerei Service Licensee Dennis C. Caproll 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23s. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one causa on each line. Approximate Intervel Between Onset and Death ACUTE MYOCARDIAL INFARCTION Immediate Ceuse (Finei 2 DAYS disease or condition resulting in deeth) Due to (or as a consequence of): CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Part ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? GASTROINTESTINAL BLEEDING 1 Yes 2 No 1 Yes 2 0 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Menner of Deeth 28s. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Examiner Examiner physician and the burief-transit that the death certificate be executed Box 68760. Physician/Medical P.O. signed by the Records, þ The law requires Completed page 2 certificate Division of Vital Physician: Be Certification: To this funeral After or Attanding death. after death 6 24 hours after Funeral Dire letely filled in b Hospital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death

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filed within 72 Hygiene.

permit. Pages 1 and 2 should be file Department of Heelth, and Mentel Hy Important: If item 27 is marked oth any Injury or other traumatic avam any Injury or other traumatic avam

Physician

/Medical

altimore. Maryland 21215-0020

Director

Funeral

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Completed

Be

MD.

PULMONARY EDEMA

25. Was case referred to medical axaminer? 1 Yes 2N No

5 Pending investigation

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted.

(Check only one) 29b. Signature and title of certified

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29a. Certifier

2 Accident

3 ☐ Suicide

4 Homicide

multo mo

29c. License number D41410

29d. Dete signed (Month, Day, Year) Felbruary 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER MEHTA, M.D., 7601 OSLER DRIVE, TOWSON. MD 21204

2001

State Registrar

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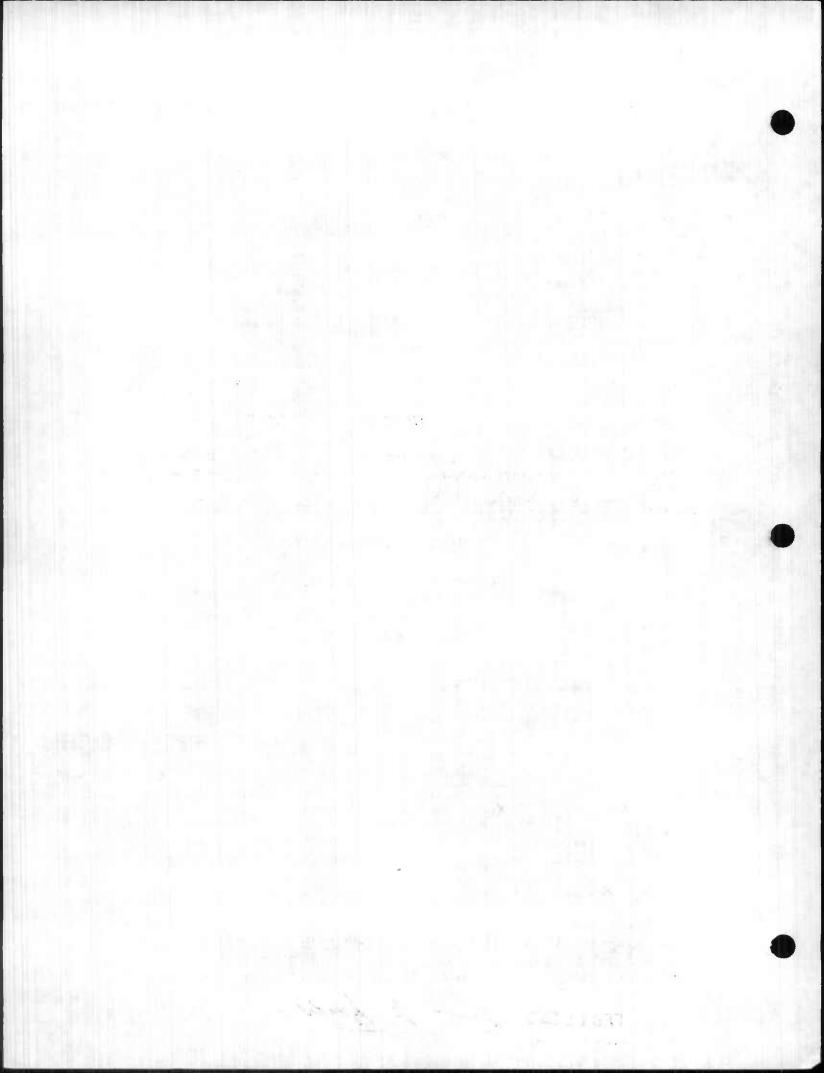
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31. Date filed (Month, Day, Year) FEB 1 6 2000

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32. Registrer's Signature

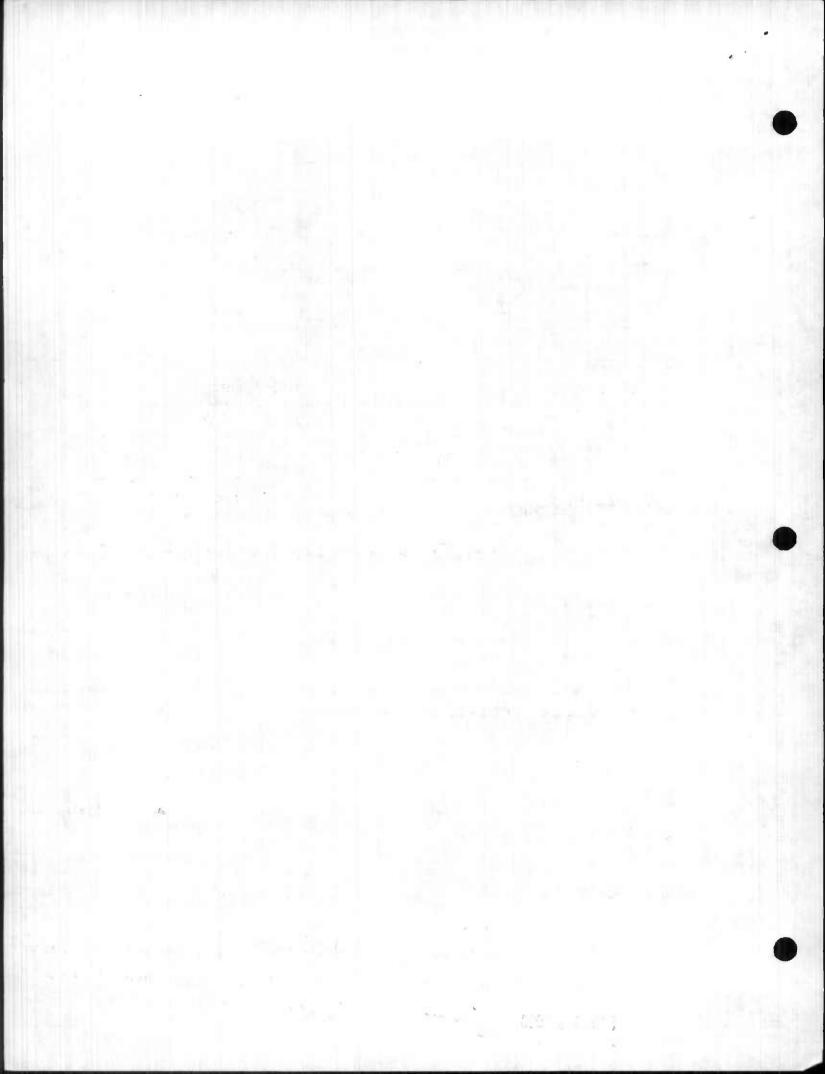
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Feb. **Physician** 3:15 PM 2000 Mildred V. Welsh /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore Hours Min. 8. Date of Birth Carl Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 TF 94 Director 215-50-9461 MD Usual Residence of Decedant 10a Stata 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or itema 23a or 28a-f ahov the Medical Examiner must be notified at MD Baltimore Towson 1 ☐ Yes 2 X No Funeral Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Sussex Rd. 21286 USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus 1 ☐ Never Married 2 ☐ Merried White 1 ☐ Yas 2 No Specify: þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker **OwnHome** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Isabel Thomoson William Conway 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 Is m any injury or other traum Joseph P. Carroll/Son 211 Treherne Rd. Timonium MD 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 2/14/00 Timonium, MD Dulaney Valley Mem. Gardens 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Service Licensee Matthew T. Canapp 22. Neme and Address of Facility Ruck Towson Funeral Home Inc. 1050 York Rd. 21204 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** pocardial infarction /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): USB 88 I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 100 3 Probably 4 Unknown Division of Vital Records, P. <u>Á</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes certificate or Attending Physician: funeral director, 8 25. Was casa referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 ROther (Specify Medical Certification: To 1 Yas 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide Hospital The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar completely (Check only one) within 2 29b. Signatura and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 6-BMC 2 6701 32. Registrar's Signature Registrar FEB16 2000 **DHMH 16 Rev 6/95**

ORIGINAL



l Wieczyr	nski, J:	r.			State	of M	arylan	d Department of Health and M Certificate of Death	ental Hygiene	01	8	70
AMEND IT	EMS: #2	3 PART	1,	27	PER	MEO	G781	Certificate of Death	Reg. No.			

Physician	
/Medical	
Examiner	

Michael F. Wieczynski, Jr. 4a Facility Neme (If not institution, give street and number) 333 S. Bentalou Street

1. Decedent's Neme (First, Middle, Last)

5. Social Security Number UNK 6. Sex

4b. City, Town, or Location of Deeth Baltimore

3. Time of Death Month Dey February 11, 2000 5:25 P.M. 4c. County of Deeth

Funeral Director

1 M 2□ F Usual Residence of Decedent 10e State 10b County

7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours

N/A

Yrs. 10c. City, Town or Location

10f. Zip Code

8. Date of Birth (Month, Day, Yea 04-20-64

2. Date of Death

 Birthplace (State or Foreign Country) MD

10d. Inside City Limits

1 □Yes 2 □ No

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

à

Completed

the Maryland

death

permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiena. Introcram: if hem 27 is marked other than "natural; or hem any injury or other traumatic avent, the Median Pages."

Baltimore, Maryland 21215-0020

MD n/a 10e. Street and Number

Baltimore

333 Bentalou Street

21223 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10g. Citizen of What Country? USA

11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:

35

1 ☐ Yes 2√ No Specify:

14. Raca - American Indien. Black, White, etc. SpeciWhite V

Elementary/Secondary (0-12)

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 0

Decedent's Usual Occupation
 (Give kind of work done during most of working life, DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Truck Driver

Trucking 18. Mother's Name (First, Middle, Maiden Sumer

George Snyder

19a. Informent's Neme/Relationship (Type, Print)

Nancy Dalehunt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

Mr. MichaellF. Wieczynski, Sr.

20b. Place of Disposition (Name of cemetery, crematory or other placa)

2618 Fait Avenue, Baltimore, MD 21224 20c. Location - City or Town, State

1 Surial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

Loudon Park

02-15-00 Balto., MD

21. Signature of Fugerith Service Licensee rocaux

22. Neme end Address of Fecility

Kaczorowski F.H. 1201 Dundalk Avenue, Baltimore, MD 21224 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ast only one cause on each line. Approximete Interval Between

Physician /Medical Examiner

physician and the burial-transit

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signed by the a

page 2 s

this funeral

An Hospital or Angelogy 24 hours after death.

Anal Director: After the further the furthe

To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by

that the deeth certificate be assecuted

Box 68760

Records.

Division of Vital or Attending Physician:

n JUNE

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Due to (or es a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown

OBESITY

24a. Wes an autopsy performed?

2 No

1 X Yes

24b. Were autopsy findings evailable prior to completion of cause of death?

1 Yes 2 No

Onset and Deeth

25. Was case referred to medical examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 XYes 2 No

26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify)

27. Manner of Death 1 Natural 2 ☐ Accident

26a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) February 13, 2000

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

5 Radentz

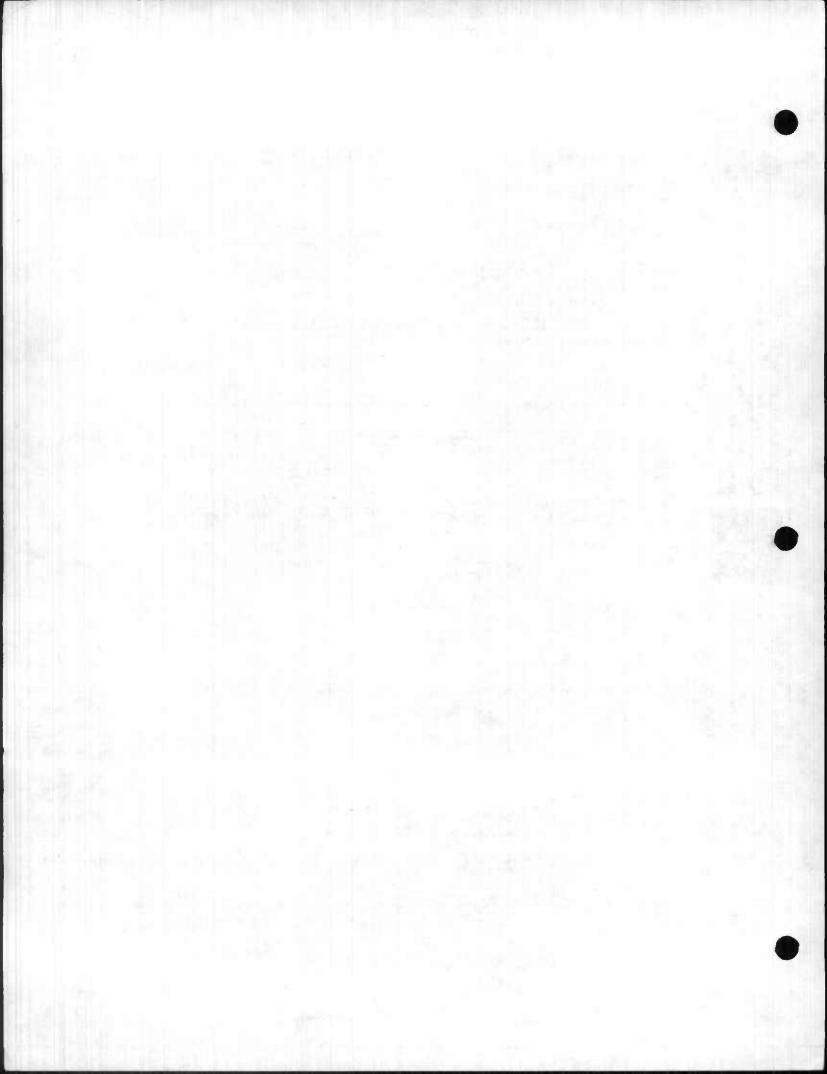
111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year) FEB 1 6 2000

32. Registrar's Signature Deper

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician Edward Wenker Young** : 40 ars teb 2000 /Medical 4c. County of Death 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death Examiner H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) February 11, 1908 Bultimore Centar narlestown Care 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 92 Pennsylvania Director 184-01-1351 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ahoa 1 ☐ Yes 2 No Director 288-7 Maryland **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or hams 23s or 21228 719 Maiden Choice Lane U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify Specify: À White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. other than Chemical Mfg Elementary/Secondary (0-12) College (1-4or 5+) Salesman 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Pages 1 and 2 should be and Mental mportant: If Item 27 is marked Joseph Young Lillian Bavington 19a. fnformant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5515 Smallwood Court Clarksville, Maryland 21029 Mr. Andrew Young 20b. Place of Disposition (Name of cametery, crematory or other place) All County Cremation Services, Inc. 02/12/2000 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from Stete 4 ☐ Donalion 5 ☐ Other (Specify) Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 elel M0/204 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart felture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical tastatic Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Lest and Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown g 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2 2/2 No 1 Yes 2/ No this certificate 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Panding investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

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altimore, Maryland 21215-0020

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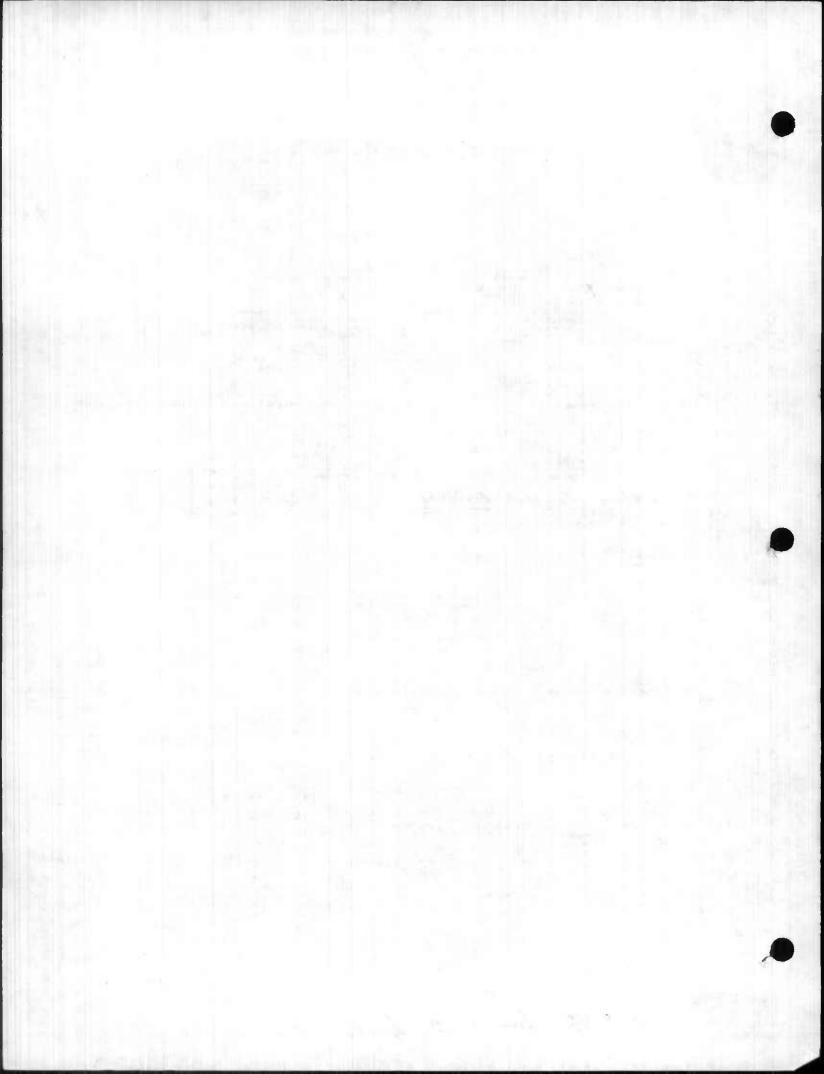
31. Date filed (Month, Day, Year)

Salarar

Andres

32. Registrar's Signature

Lane, Catonsville, MD, 21228



State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Feb. 13 2000 3:30pm. Marie F. Zaetz /Medical 4a Fscility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 711 Greentree Rd. Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthple Country Sep • 20, 1916 Ohio Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 20 F Months 216-09-8768 83 Director Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f show 10d. Inside City Limits Md. Anne Arundel Linthicum 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 Greentree Rd. 21090 U.S.A Items 23a death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. traumatic event, the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or fie 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 204Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Beauty Shop-owner 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nick Boxwell (not available) Marie 19a. Intermant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: if flem 27 is any injury or other trau Michael Zaetz/husband 711 Greentree Rd. Linthicum Md. 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp.2/18/00 Towson, Md. 22. Name and Address of Facility Gonce Funeral Home P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Hwy. Balto., Md. 21225 panerousk mua not enter the mode of dying, such as cardiac or respiratory arrest, plications that caused the death, one cause on each line. Approximate erval Bet Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical metastatic 15 wonThs vare-Examinal Due to (or as a consequence of): Examine The law requires that the death certificats be executed physician and the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause ot death? Completed 24a. Was an autopsy performed? page 1 Yes 2 No 1 □ Yes 2 □ No of Vital Physician: Be 25. Was case reterred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Division or Attending 5 Pending investigation 1 Yes 2 No death. To the Hospital or Attendivitin 24 hours after death Yo the Funeral Director: A completely filled in by the f 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40 027938 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) quahart Rd. Gleh Burnie MD 21061 MD (ouba Q. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 6 2000 Registrar

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Box 68760, P.O. Records. of Vital Division

Physician

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State Registrar

revol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONMBHO.B

29b. Signeture and title of certifier

31. Date filed (Month, Day, Year) FEB 1

32. Registrat's Signature

2000

Maryland House of Corrections Jessup, Maryland ooks

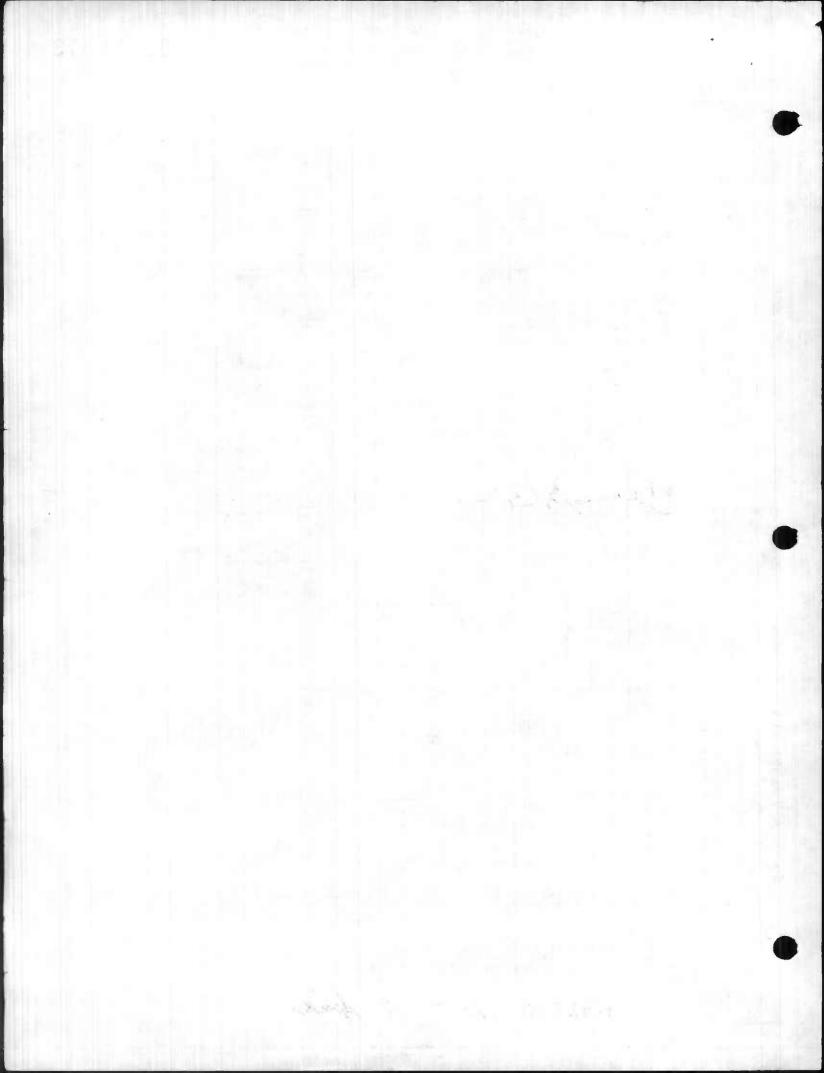
29c. License number

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29d. Date signed (Month, Day, Year)

February 17, 2000

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Physician /Medical	1. Decedent's Name (First, Mid Ronald	de, Last)	on					2. Date of De Month Februa	ry 11 2	Year 2000	3. Tima of Death 2328
Examiner	4a Facility Name (If not institut					4b. City, 1	rown, or Loc	cation of Deat	h 4c. County	of Death	
	Washington			Milled			rstown or 24 Hrs.			ingto	
Funeral Director	5. Social Security Number 147–40–5521 Usual Residence of Decedent	6. Sex 7 1. M 2□ F	7. Age (In yrs. las	Yrs. Months	Days	Hours	Min.	8. Date of Bi (Month, Di pril 1	ny, Year)	9. Birthp Coun Mt. H	lace (State or Foreign try) Holly, NJ
S 8	10a. State 10b. Coun	ly	10c. City,	Town or Location						1	Od. Inside City Limits
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death with the Ma ms 23e or 28e-t s r.mat be notified ners! Director	10e. Street and Number		1 101		ip Code				10g. Citizen of V	What Coun	itry?
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by Fu	1 Never Married 2 Me 3 Widowed 4 Divorce	N Von Cina	2 🗌 No	1□ Vaa			an, Puerto F y:	HICAN, OIC.)		k, White, or White	
te lea	15. Decede	ent's Education		16a. Decedent's Us	uat Occup	pation			16b. Kind of Bu	usiness/Inc	dustry
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reportant: If them 27 is merked o any injury or other traumetic eve once. To Be	21. Signature of Funeral Service	e Licensee		22. Name e Eckha			ility ral Ch	nanel			
2.40	3296 Charmil Dr. Manchester, Md. 2 Sa Parti Inter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, and or respiratory arrast arrangement are respiratory arrangement.										
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TO B	1 Yas 2 No			VOutpatient 3 D	UA				idence 6 Oth		(v)
inoli inoli	27. Manner of Death 1 ☑ Natural 5 ☑ Pend		i, Day Year)	8b. Tima of Injury	28c. Inju			zoa. Describe	how injury occur	Det	
ificat	3 Suicide 6 Coule	d not be	-Adalus : Att	M		Yes 2[106 Laastins	(Ctract and him t	W. C. C.	al Pouto Number
Certification:	4 Homicide detail	mined 289. Place 0	of tnjury - At homo g, etc. <i>(Specify)</i>	e, lerm, street, lecto	ry, office		2	City or To	(Street and Numb wn, Stete)	oer or Hura	I Houte Number,
iely fil	29a. Certifier 12 Certify (Check only one) 14 Medica	ing Physician: To the ball Examiner: On the bas and manner	sis of axamination	edge, death occurred and/or investigation	d at the ti	me, date a	end place, e	end due to the	cause(s) and ma date and place,	anner as st and due to	tated. o the cause(s)
To the Funeral completely filled	29b. Signature and title of certif		- waidd.	29	c. Licens	se numbe			29d. Date signe	d (Month.	Day, Year)
10	Gl. Ban	Ma					.313				2-00
00	00 1	<i>y</i>	-4 -4 - 14 -47		700	,					
)	30. Name and address of perso	n who completed causa			rrit	44	11	+	in, Md		
CANA	31. Date filed (Month, Day, Yea	T. A. Anna	gistrar's Signatur		100	1	MAG	CYS/OW	in, Ma		
State Registrar	FFR 1	7 2000	heren	.4	1	. 20					

TO SERVICE OF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death

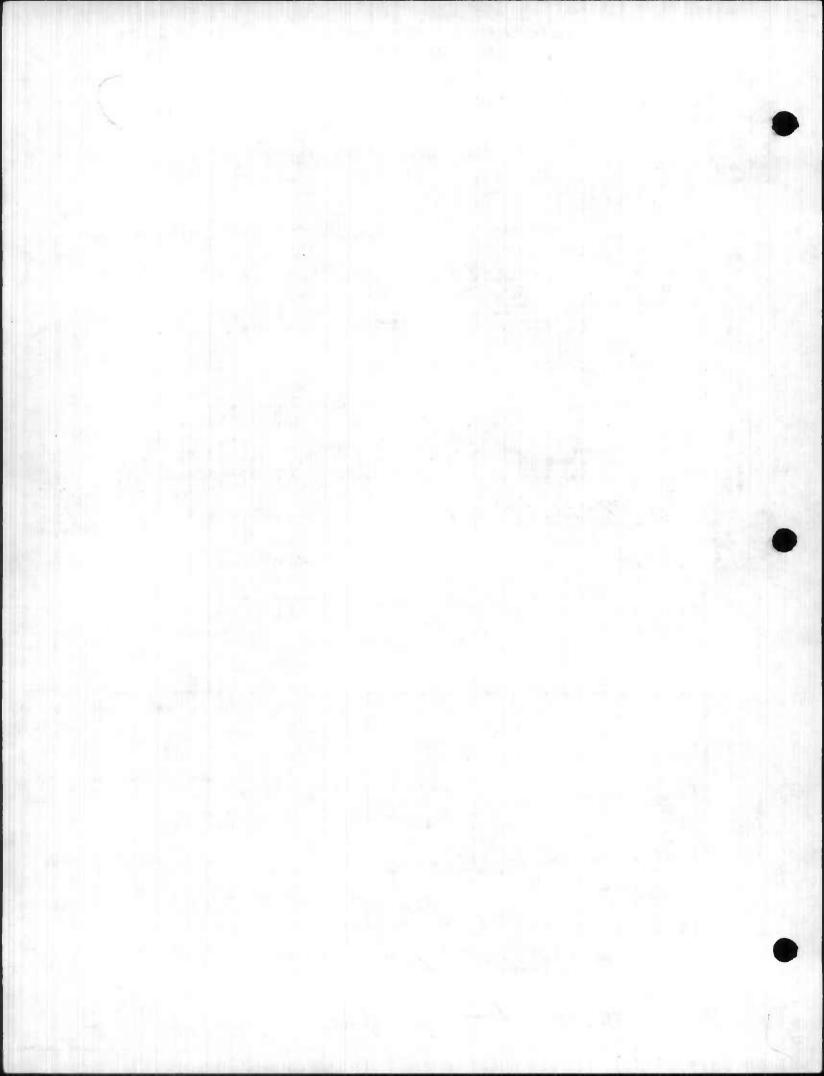
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sician edical miner 4s N	Decedent's Name (First, Middle, Last, JOSE RODOLFO Facility Name (If not institution, give MERCY HOSPITAL) Social Security Number 6. Se; 10 10 10 10 10 10 10 10 10 10 10 10 10	BADOS street and number)	e (In yrs. last birl		der 1 Year	4b. City, Town	For Location	Date of Death Month EBRUAR on of Death	Day			
edical miner 48 N	Facility Name (If not institution, give MERCY HOSPITAL Social Security Number 6. Sec. 665-32-3872 10 ual Residence of Decedent a. State 10b. County	street and number)			dos 1 Vons	BALTI	, or Location	EBRUAR'	Y 12,20	000 of Death		
5. S 5 5 5 5 10e	MERCY HOSPITAL Social Security Number 6. Sec. 10 65-32-3872 10 ual Residence of Decedent a. State 10b. County	x 7. Age			des 1 Vens	BALTI	MORE	on of Death		of Death		
Or South	103 103 103 103 103 103 103 103 103 103				dor 1 Voor							
10e	a. State 10b. County		73	Yrs. Month			Min	Date of Birth Month, Day, -28-19	Year)	9. Birthi Coul HO	place (State or Fore ntry) NDORUS	
	MD		10c. City, Towr	n or Location							10d. Inside City Lim	
		BALTIMORE						1 √ Yes 2 [
15	201 WARREN AVENUE, APT 304					21230	10	10g. Citizen of What Country? U.S.A.				
by Fur	Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto				Yes or No- in, etc.)	14. Race - American Indian, Bleck, White, etc. Specify: WHITE			
Completed	15, Decedent's Education (Specify only highest grade completed)			Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)				1	16b. Kind of Business/Industry			
Comp	Elementary/Secondary (0-12)	College (1-4or 5-	College (1-4or 5+) MECHANIC					VENDING MACHINE C			HINE COME	
17.	ET TORO DIDOG					Name (First, Middle, Maiden Surname) [A MENDOZA]						
190	a. Informant's Name/Relationship (Ty FILBERT E. HORAK	rpe, Print) STEP-SON				VENUE,	DO Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21227					
	20a. Method of Disposition 1 \bigsim Burial 2 \Boxed Cremation 3 \Boxed Removal from Stete 4 \Boxed Donation 5 \Boxed Other (Specify) 20b. Plece of Disposition (Name cemetery, crematory or othe MEADOWRIDGE CEI					ice)	02-	16 2	20c. Location	City or To	•	
er disc res	mediate Cause (Finet lease or condition sulting in death)	Athero	Sclenoti Due to (or as a c			ovaslu	lar	disa	east	1		
Sec if ar cau	Sequentially list conditions, if any, leading to immediate cause. Eriter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):											
S rest	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d											
Phy	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tol	~		o the cause of dea	
Completed by								24a. Was an perform	hed?	av cc of	fere autopsy finding railable prior to ompletion of cause death?	
9 25.	25. Was case referred to medical 26. Place of Death (Check only one)									Yes 2 No		
2					patient 3 DOA Other: 4 Nursing Hor				flome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
2	2 Accident investigation 3 Suicide 6 Could not be determined	investigation M 1 Yes 2 No					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
T T												
9	a. Certifier 1 Certifying Phys (Check only one) 2 AMedical Examir	sician: To the best of ner: On the basis of a and manner stet	examination and	death occurr Vor investigeti	ed at the ti ion, in my o	me, date and popinion, death	place, and occurred a	due to the ca t the time, da	use(s) and ma ite and place,	anner as s	stated. o the cause(s)	

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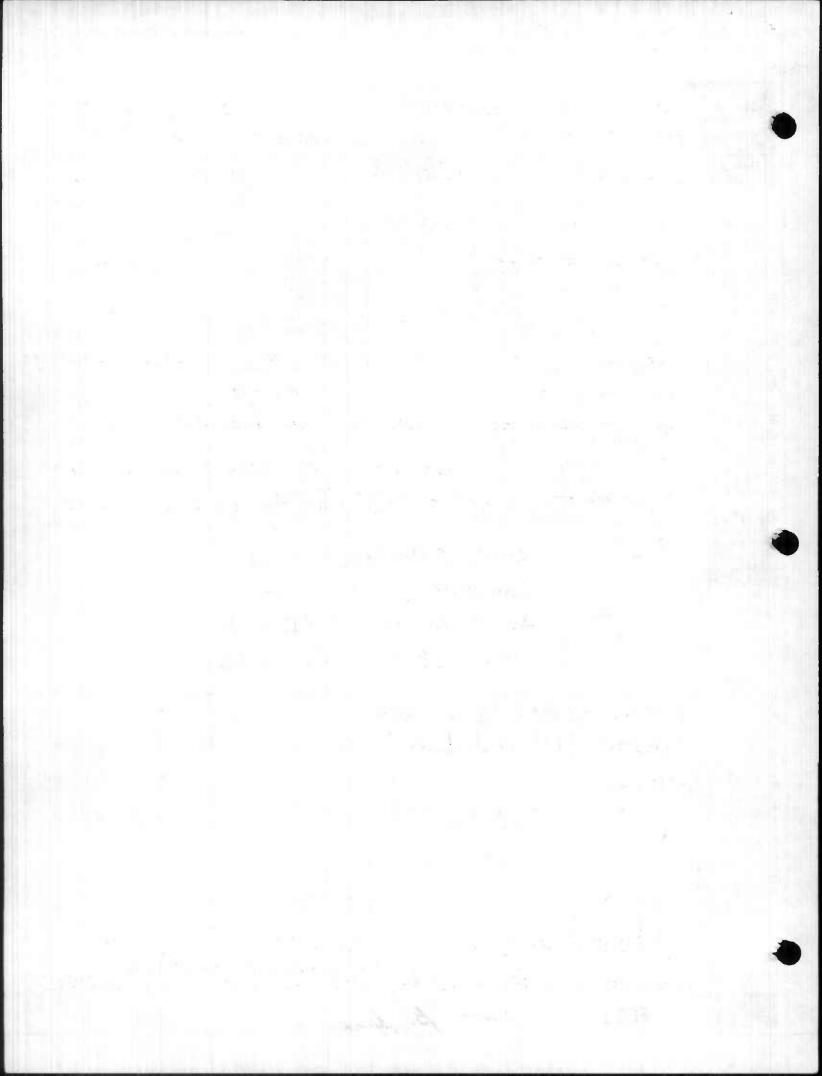
State Registrar

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

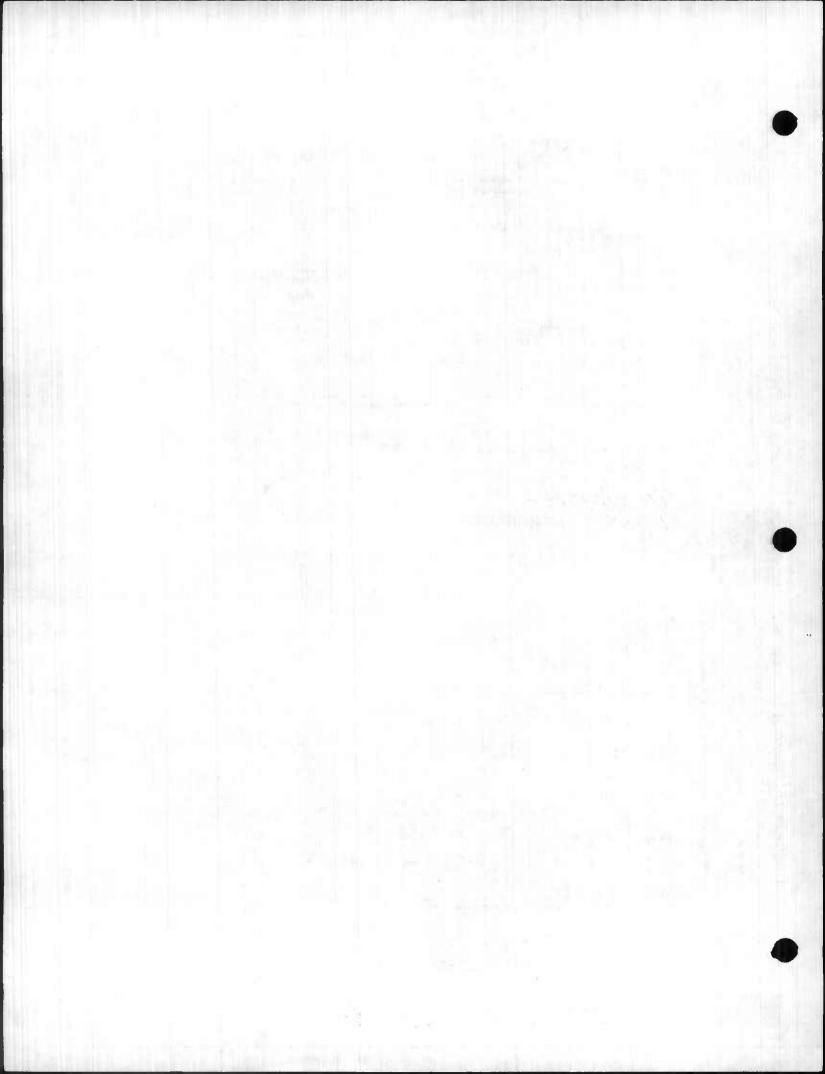
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month AUDIA BROWN 5: IFPM /Medical 4a Facility Name (If not institution, give street and jumber) AL 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE BALTIMORE If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stata or Foreign Country) **Funeral** Deys Hours 1 ■ M 2 💢 F Yrs. Director 169-20-9988 Usual Rasidence of Decedant 76 01 24 N.C 10e, Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mooical Examiner must be nothing at 1 ¥Yas 2 No Director MD NA Baltimore 10e. Street end Numbar 10f. Zip Coda 10g. Citizan of What Country? 3739 Reisterstown Road 21215 U.S.A. 12. Was Dacedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest greda complated) 16b. Kind of Businass/Industry se filed within 7 al Hygiene. Elamentary/Secondery (0-12) Collaga (1-4or 5+) 12 grade 17. Fether's Nema (First, Middla, Last) Marylander Apartment Telephone Operator 18. Mothar's Nama (First, Middla, Maidan Sumama) 12 should be find and Mental H Be Ernest Weathers Ora Lucky 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) permit. Pages 1 and 2 : Department of Health ar Important: If Item 27 is any injury or other trau 7012 Alden Road, Pikesville Md Ann Stepney-Daughter 21208 20b. Place of Disposition (Nema of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Bural 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Contation 5 ☐ Other (Specify) King Memorial Park 2/19/00 Randallstown, Md gf Funaral Sarvice Acens March F/H West
4300 Wabash Ave, Baltimore Md
Wash, or haart failura. List only one ceuse on aach lina. 21215 Approximeta Intarval Batween Physician /Medical Imma Tata Cause (Final . COAGULOPATH diseese or condition resulting in death) Examiner Examiner and -trans Sequantially list conditions, if eny, leeding to immadiata ceusa. Entar Undarlying Ceusa (Disaasa or Injury that initiated evants rasulting in death) Lest physician ar s tha burial-ti Box 68760. Physician/Medicai P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy performed? SEPSIS 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Was cesa referred to medicel axaminer?
1 ☐ Yas 2 ☐ No Be 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpetient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 28a. Data of Injury (Month, Dey Yeer) 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Neturel 2 Accidant 5 Panding 1 Yas 2 No invastigation 6 Could not be datarmined 3 Suicida Location (Straat and Number or Rural Route Number, City or Town, Steta) 26e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifian Medicai 29d. Data signed (Month, Day, Year) and title of certifian 29c. Licansa number D45925 ATM OCK 30. Nama and addrass of person who complated ceuse of daeth (Item 23e) (Type, Print) Bon SECOURS HOSPITAL CHUKWUEMEKA LIFOMADU MI). 2000 BALTIMORESTREET, MD 21215 31. Data filad (Month, Dey, Year) 32. Registrar's Signatura State FEB 1 7 2000 Registrar Spark



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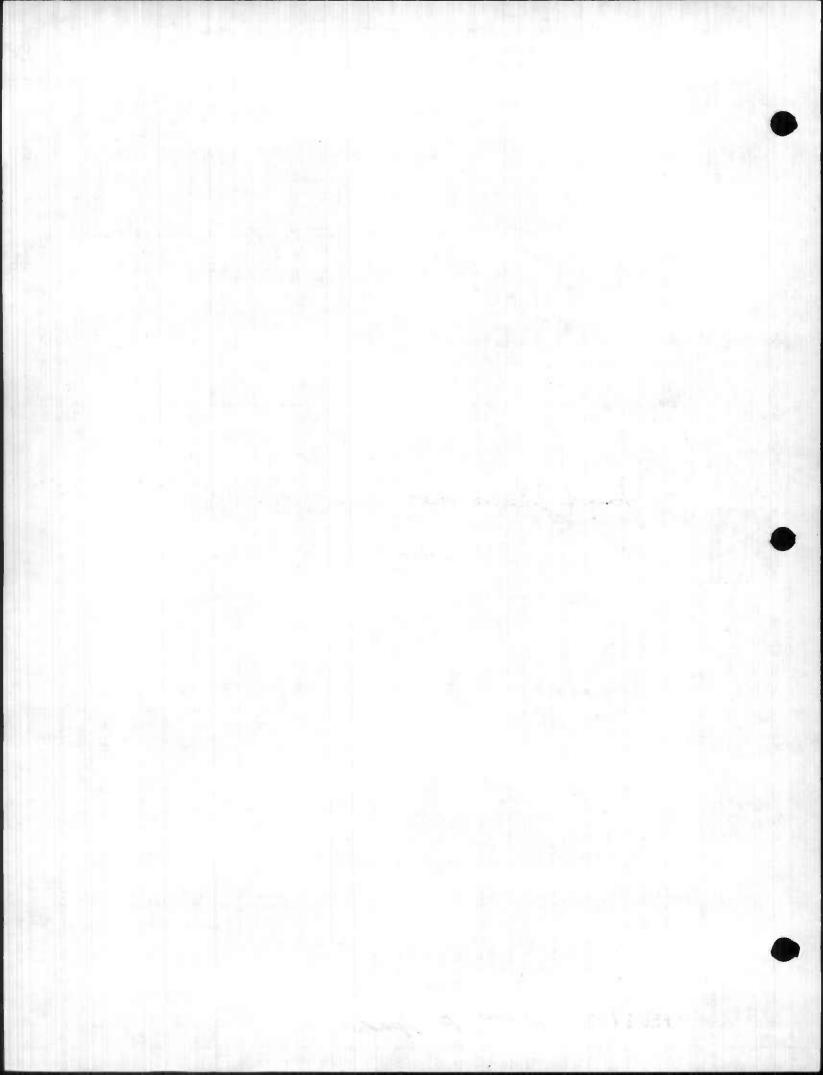
State of Maryland / Department of Health and Mental Hygiene 1 4 8 7 7

					Certificat	e of	Death	R	leg. No.			
		1. Decedent's Neme (First, Middle	, Last)					2. Date of Dea	th		3. Time of Death	
	Physician	Satyawati Bh				January	Day 28, 20	Year	9:20 p.m.			
	/Medical Examiner	4a Facility Name (If not institution					b. City, Town, or Location of Death		4		3.20 p.m.	
	LAMINICI	Laurel Regional Hospital Laurel Prince (eorge	
1020 June after death with the Mandand	Funeral Director	5. Social Security Number 218-11-7246	Months Days					rs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Fore Country) Feb. 1, 1923 India				
	2	Usual Rasidence of Decedent 10a. State 10b. County		10c City Tow	m or Location					140	od Inside Cibed in its	
	Manyta 4 show led at 10r								10	od. Inside City Limits ty□ Yes 2□ No		
	er death with the Marys thems 23s or 23s-t sho ner must be notified at uneral Director	10e. Street and Number 10f. Zip Code						1	l0g. Citizen of V	What Count	try?	
	ath wi	1004 Montrose	20707				USA 14. Rece - American Indian.					
	ar, or he Examine by Fur	1 Never Married 2 Mam 3 Widowed 4 Divorced	nt Ever in U,S. s?] No ::	ar in U,S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 No Specify:			Specify: A:					
50	TZ. h		15. Decedent's Education (Specify only highest grade completed)		Decedent's Usua	al Occup	upation a during most of working ad)		16b. Kind of Br	usiness/Ind	ustry	
121	ed within 72 ho yglena. Ar then "neture A. the Medical. Completed	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+)									
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	nd 2 sho lifth and 27 is my r freum	19a. Informant's Neme/Relations Naresh Bhadou					(Street end Number or Rural Route Number, City or Town, State, Zip Code) Ins Road, Laurel, Maryland 20708					
é,	1 and Health wm 27 other tr	20a. Method of Disposition	LIA/SUN	20b. Place 0	f Disposition (Nar	me of		T	20c. Location -			
Baltimore,	BON OF STATE	1 Burlal 2 Cremetion		e cemete	ry, cremetory or o	other plea						
=	ortan Injury	4 Donation 5 Other (Sp 21. Bignature of Funers Surger		Dalti	22. Name ar			1/31/00	Laure	L, Mai	ryland	
Ba	Dep Party Barry Ba	WI KM	-11		171	.1. 17.		lome, Inc.				
		23a Parti Enter/for Shelsen, or phock, or porti tiliure. List	complications that cause	ad the death. Do	7601	Sand	y Sprin	g Road, I	aurel,	Mary	Land 20707	
1	Dhusisian /	phock, or beart taliure. List	only one cause on each	line.	not onto, are mod	o or oyn	rg, odon do odra	ac or respiratory arr	001,		Intervel Between Onset and Death	
	Physician // // // // // // // // // // // // //	Immediete Cause (Final	~	C = -0:	-1 1.	. 0	an chi	00				
п	Examiner	disease or condition resulting in death)	0 11140	Due to (or es e	2 1	M	erco,			15	30 minules	
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Вох	at the death certical by the attending etached for use a Physician/M		d									
	the a hed i	Pert II. Other significant conditio		_				23b. Did to	obacco uae co	ntribute to	the cause of death?	
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Be	he law e has age 2	U						1 U Y	es 20No		Yes 2010	
Vital		25. Was case reterred to medical					26. Place of D	eath (Check only or			1,100 2,2.10	
<u>></u>	Physician: this certific rel director.	examiner?	Hospital:	tient 2 ER/Ou	rtpatient 32 0	OA Oth	er	Home 5 ☐ Reside		er (Specify	1)	
10		27. Menner of Death	28a. Dete of In						28d. Describe how injury occurred			
Ö	Attending or death. ector: After by the fune liffication	1 Natural 5 Pending		Yes 2□No								
Division	tal or Attending P rs after death. al Director: After t led in by the funer Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 289. Piece of I	njury - At home, fa etc. (Specify)	, farm, street, factory, office 28f. Loca City			28f. Location (Si City or Town	cation (Street and Number or Rural Route Number, y or Town, Stete)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier 12 Certifying (Check only 2 Medical E	Physician: To the bes examiner: On the basis and manner:	of examination en	e, death occurred d/or investigation	at the tir	ne, date and pla- pinion, death oc	ce, end due to the c curred et the time, d	ause(s) and mi lete and place,	enner as sta and due to	ated. the cause(s)	
	To the comple	29b. Signature and title of certifier	· .		290	c. Licens	e number	2	9d. Date signe	d (Month, L	Day, Year)	
	FSFO	1 Robert m) DZ3181 1-29-200								000		
	n.M.	30. Name and eddress of person v	who completed cause of	death (Item 23a)								
	141	R'4. BHOJI	EAJ MD.	7040	TOYMa	m 1	Ave#	T-1. La	urel,	MD	20707	
	State	31. Date filed (Month, Day, Year)	- 1	trar's Signature	4 1	lan.	1.		/			



State of Maryland / Department of Health and Mental Hygiene

		Certificate of			g. No.						
		Decedent's Name (First, Middla, Last)		2. Date of Death		3. Time of Death					
Physicia /Medic Examin		Jennie C. Biscotti		Feb. 12	, 2000 Year	2:38a.m.					
		4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death	4c. County of Deat	h					
		Sykesville Eldercare	Sykesvill ear If Under 24 Hrs.	8. Data of Birth	Carroll						
	Funeral Director	5. Social Security Number 213-03-6233 Column Column	1912 ft	hplace (Stata or Foreign unitor) .aly							
020	ter death with the Meryland terms 23a or 28s-f show instrument be notified at Tuneral Director	10a. Stata 10b. County 10c. City, Town or Location Baltimore									
	r 28s	10e. Street and Number 10f. Zip Cod	109	g. Citizan of What Co	untry?						
	23a c	6225 York Road Apt. 322 N. 212	212-2645		United Sta	ites					
		1 Nevar Marriad 2 Merried 1 Yas 2 No	of Hispanic Origin? (Sp Juban, Mexican, Puerto No <i>Specify:</i>	ecify Yas or No- Rican, atc.)	rican Indian, a, atc. Vhite						
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an	build be filed with Mental Hygiene. Freed other ther etic event, the To Be Comp	Paul Micriotti		Carmela							
-	d 2 sh th and th am traum	19a. Informant's Name/Reletionship (Type, Print) Mrs. Paulette Turkel - Niece 12747 Folly				the same of the sa					
Baltimore,	Pages 1 and nent of Health int: If them 27 irry or other tr	20a. Mathod of Disposition 1 National 2 Cramation 3 Removel from State 20b. Plece of Disposition (Nema or cematary, crematory or other)			Oc. Location - City or						
tim	Department mportant any Injury	4 □ Donation 5 □ Other (Specify) Most Holy Redeet 21. Signature of Funerel Service Licensee 22. Nema end Ad									
Ba	permit. Pages Department of I Important: If its any injury or or once.	22. Nome of Author of Service Licensee Rolling May 373 8728 Libe	Funeral I wn, MD 21	Directors, Inc 133-4784							
		23a. Part 1. From the disease, or conf. lications that caused the deeth. Do not enter the mode of shock or heart failure. List only one cause on each line.	dying, such as cardiac	or respiratory arres	it,	Approximata Intarval Between					
	Physician /Medical Examiner	Immediate Cause (Final disassa or condition resulting in death) e.	Disor	sas	1	Onset and Death					
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	ifficate be executed g physician and as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or injury c.									
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Records,	requir een s hould	Discover	24a. Was an performe	ed?	Were autopsy findings available prior to completion of cause						
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ta	entificat sctor, p	25. Was case rafarred to medicel	26. Place of Deet	1 ☐ Yes		12 100 22 10					
>	Physician: this certific ral director,	examinar? 1 Yes 2 Ne Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other:		ice 6 Other (Spec	city)					
ivision	Attending Ph or death. ector: After thi by the funeral	27. Menner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) Accident investigation	28d. Describe how injury occurred								
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	To the Hospital or Attending Physician: The is within 24 hours after death. 19 the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) end manner as stated. Check only one) Check only one) Check only one)									
	Vithin within ample	29b. Signature and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year)									
		Nelet Robert B. Kroppnick MP. 752-MO 2/11/00.									
	HYV	30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)	Konill	Ma	20	12008					
	State	31. Data filed (Month, Day, Year) 32. Registrar's Signatura	201011	4 110	700						
	Registrar	FFR 1 7 2000 Senerte 4									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year Nellie Mitchell Bigwood February 14, 2000 8:50 P.M. 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Ruxton Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Min. 1□ M 2□ F Hours Yrs. 214-38-3178 83 8-4-1916 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 810 Providence 21286 Road U. S. A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give² Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Merital Stetus 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Thomas Howard Mitchell Mary Amelia Price 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Maryland 21286 Mr. James M. Bigwood (Son) 810 Providence Road, Towson, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 2-17-00 Cambridge, Maryland Greenlawn Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 1050 York Road, Towson, Md. 21204 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 → Unknown 1 ☐ Yea 2 ☐ No 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2€ No 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

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Certification: To

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The law requires that the death certificate be executed

Physician:

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P.O.

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Division or Attending **Physician**

/Medical

Examiner

10a. Stete

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Funeral

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Completed

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Director

Hygiane. Hydrane Than Thatural', or frame 23s or 28s-f show rant, the Medical Examinar must be notified at

7 is marked other traumatic avent,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Itam 27 is marked othe any injury or other traumatic avant, pages.

the Maryland

with

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by

25. Wes case referred to medicat examiner? 1□ Yes 2□-No

28a. Date of Injury (Month, Day Year) 5 Pending investigation

Hospital:

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a, Certifier (Check only

27. Manner of Death

14 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Carifying Physician: To the best of my knowledge, seeith occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or eventigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. milligation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of pertific

6 ☐ Could not be

29c. Ligense number

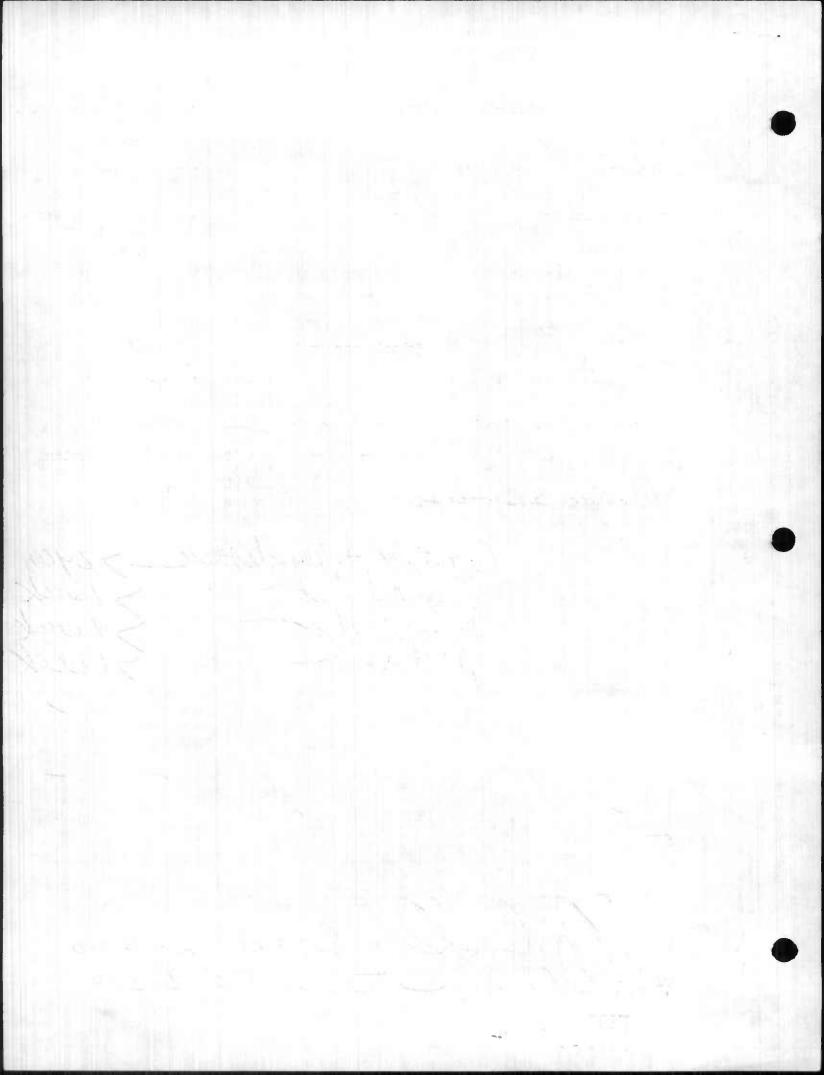
29d. Dete signed (Month, Dey, Year)

30. Name and address of per pluted causaĵof death (Item 23a) (Type, Print)

State Registrar

2000

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are pegible: 1, 880

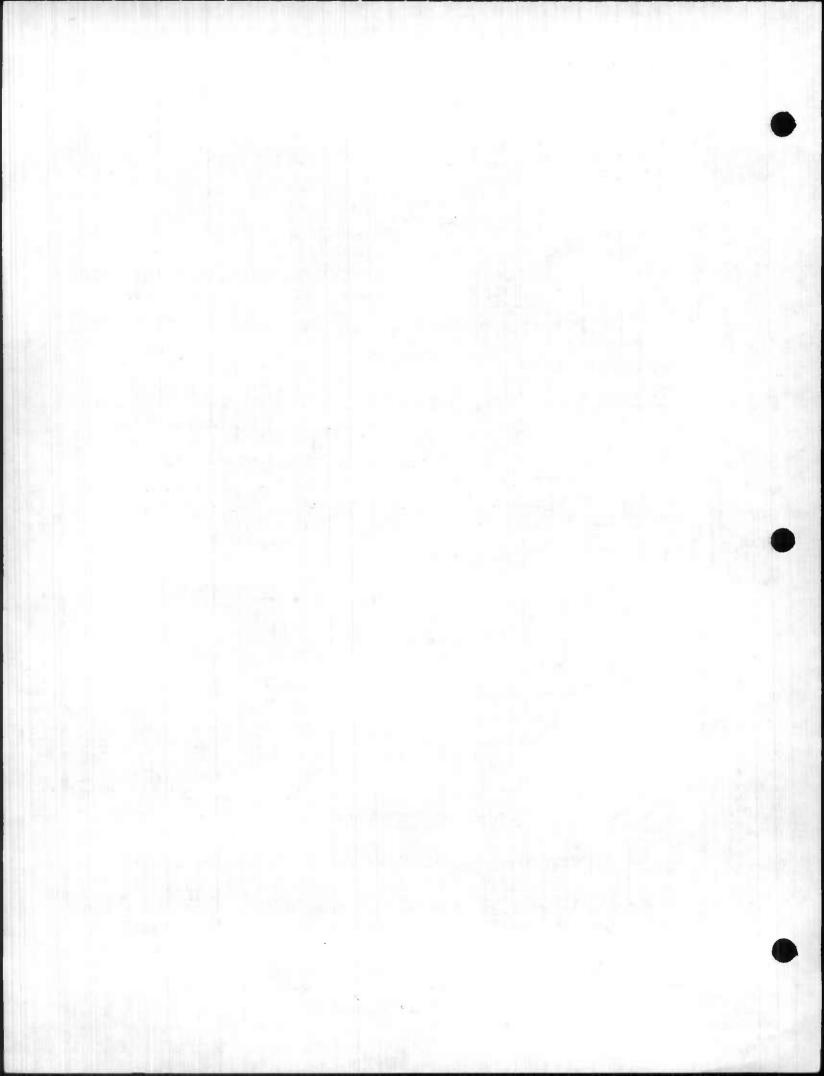
State of Maryland / Department of Health and Mental Hygiene

AMEND #5 PER F.H. G780 2-17-2000 JAB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dat Month Vear **Physician** 7:15 pm February 14 2000 **BLOCK** /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 24 Hrs. 8. Data of Birth
JUNE 21 1914 7. Aga (In yrs. last birthday) If Under 1 Year 9 Birthplace (State or Foreign 5. Social Security Number 216-03-4991 **Funeral** Days Months Hours 1□M XXF 85 FLORIDA Director 220-30-0957 Usual Rasidence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylan 1√2 Yes 2 No Director MD N/A BALTIMORE 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b B30 W. 40TH STREET 21211 USA Norma 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, Whita, atc. "natural", or Iter edical Examiner 72 hours after 1 ☐ Yas 2 ☐ No If Yas, Give X 1 ☐ Nevar Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: SpecifWHITE by 3 Widowed 4 Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Other then "n Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If fleen 27 is marked other any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 EMIL BERNSTEIN CLARA WALTER 19e. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN LAMARTINA/DAUGHTER 12051 ROCKWELL WAY BOCA RATON, FL.33428 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremetion 3 Removel from Steta 4 □ Donation 5 □ Othar (Specify) BALTIMORE HEBREW CONG. 2/16/00 BALTIMORE, MD. 21. Signature of Euneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approxima Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Mesentenc pour! Ischema Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical the Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably Unknown Laver by 24b. Were autopsy lindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 21200 1 Yas 2 No or Attending Physician: 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Affer 1 Natural 2 Accident 5 Panding Mine death. 1 Yes 2 No investigation 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) in by 4 Homicida 24 hours 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier AT 2438946 Pebrune 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) Harrison Johnson MD, 201 E. University Parkway, Balkmere MD 32. Registrar's Signatura 31. Data liled (Month, Day, Year) FEB 7 2000 Registrar

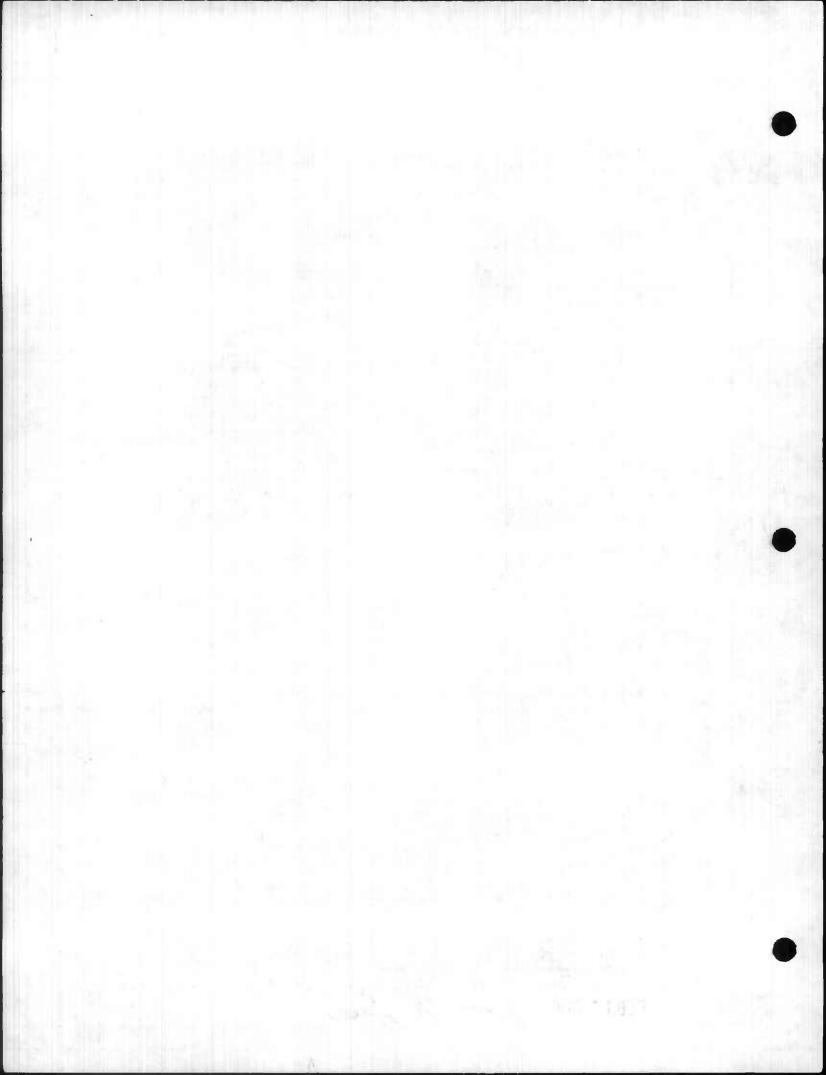
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State of Maryland / Department of Health and Mental Hygiene 1 4 8 8 1

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	Physician	1	1. Decedent's Name	ALC: LE PRINCE	ist)			B	FOL	un	2. Date of De Month Celyruan	Day	Year Z 000	3. Tima of Death	
	/Medica Examinei		la Facility Name (#		ve street and num	nber)				4b. City, Town, or I		1	ty of Death		
			Johns H		Bayvi						ore, M		Him		
ı	Funeral Director		5. Social Security Nu 219-78-	8118	Sex 1 M 2 X	7. Age (In yrs. 41	last birthday) Yrs.	Months 1	Days	If Under 24 Hrs. Hours Min.	(Month, Da	th ay, Year) 2, 1958		place (State or Foreintry)	ign
	pue &	- 1-	Usual Residence of I	Decedent 10b. County		10c. Ci	ty, Town or Lo	cation					1	10d. Inside City Limi	its
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	h with the Me 23a or 28a-f a at be notified	2010	10e. Street and Num 208 So		llas Co	urt		10f. Zip	Code	21231		10g. Citizen o		ntry?	
Baltimore, Maryland 21215-0020		ny run	11. Marital Status 1日内ever Marrie 3日 Widowed 4		12. Was Dece Armed For 1 Tyes If Yes, Give Year or Da	ces? 2 1211 0				dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black			
	c - 4	The latest	(Specification (Speci	15. Decedent's E y only highest gri dary (0-12) Tade	ducation ade completed) College (1-	4or 5+)	16a. Deced (Give life. L Home	kind of wo DO NOT u	ork done se retire	during most of wor	king	16b. Kind of Self			
	THO P	2	17. Father's Name (First, Middle, Last) 18. Mother's Name							18. Mother's Nen Flori	ne (First, Middle	, Maiden Sumi		2	
	nd 2 a	-	19a. Informant's Nar Florin	ne/Relationship (e Browl	Type, Print) O mot	her	19b. Mailin 208	S • D	s (Street	and Number or Ru as Ct.	ral Route Numb Baltin	er, City or Tow IOTE, I	n, State, Zip Md • 2	Code)	
	20-2		20a. Method of Dispo 1XXV urial 2 4 Donation 5	Cremation 3	Removal from S	state	Place of Dispo cemetery, crem shell	natory or o	other pla		Data Feb. 18	20c. Location - City or Town, Stata 8 Baltimore, Md.			
Balt	pemit. Pag Department Important: Il eny Injury o	1	21. Signature of Fun	1-20	mee Mu L					ess of Facility N	Nutter F PKWY Ba			•	
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			Due to (or as a consequence of):									1 4			
	oracuted in end fel-transit		Cause (Disease or injury that initiated events Due to (or as a consequence of):								O month	S			
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	0 0 0		Part It. Other significant conditions contributing to death but not resulting in the						ause giv	ven in Part I.	d tobacco use contribute to the cause of death?			th?	
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Ita	certificate rector, pay		25. Was case referre	d to medical						26. Plece of Dea	ath (Check only	one)			
o	this ald		1 ☐ Yes 2 N 27. Manner of Death 1 Matural	5 Pending	28a. Date o		28b. Time of Injury	1	28c. Injui Wo	y at rk?	ome 5 Res 28d. Describe	idence 6 00 how injury occ		(y)	
Division	tal or Attending P is effer death. al Director: Affert ed in by the funering Certification:		2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigatio 6 Could not b determined	e 28e. Place	of Injury - At h g, etc. (Speci	ome, farm, str fy)	M 1 Yes 2 No				(Street and Nur wn, State)	reet and Number or Rural Route Number, , State)		
	Hospit 24 hours Funer tely fill		29a. Certifier (Check only 2 one)	Certifying Ph	nysician: To the t niner: On the bas and mann	sis of examine	owledge, death ation and/or inv	occurred	et the tie	me, date and place opinion, death occu	, and due to the erred at the time,	cause(s) and i date and place	manner as a e, and due t	itated. o the cause(s)	
	To the comple		29b. Signature and tr	tle of certifier	^			29	c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)	
			1 Kel	min	5,1	100525	taff		RE	5-000		februar	7,1	4 2000	
	X	3	30. Name and address	of person who	ones, 1	ID	Johns	Print) Hexp	kmy	, Hospita	J, F	februar Baltin	ore,	MD	
	State Registrar	1	31. Date filed (Vogt)	1 7 2000	32/ Re	gistrar's Sign	ature 6	Spa	de	/					

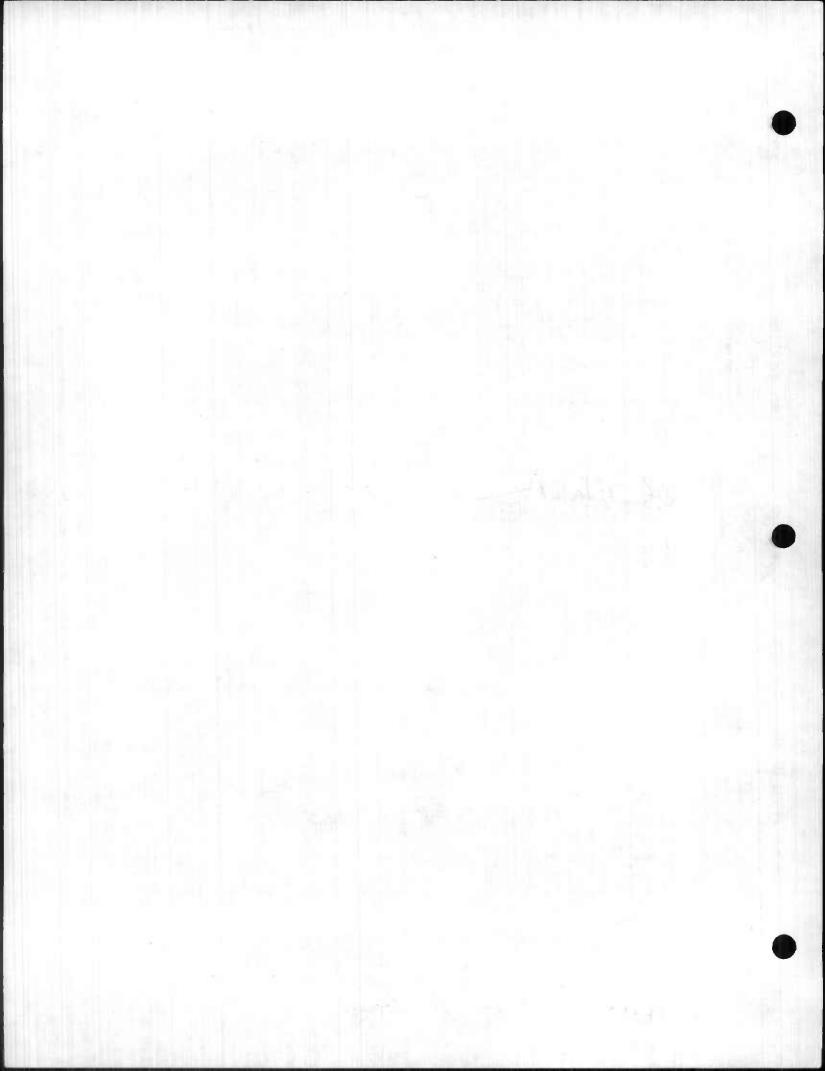
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 1,882

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month **Physician** February 15,2000 Mary Mitchell 2:13 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2□F Yrs. 213-12-3306 81 April 1,1918 Director **Uaual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. tnaide City Limits 28a-f show I7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at N/A Maryland Baltimore 1√Yes 2□No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 908 Dartmouth Road 21212 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Stetus filed within 72 hours after 1 ☐ Yes XX No If Yea, Give Year or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Induatry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important if Nem 27 is marked other the any Injury or other treatment. Insurance Underwriter 4 Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Guy Kissenger Nellie Mitchell 0 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Barnard/ Son 908 Dartmouth Road Baltimore, MD 21212 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 2/17/00 Beltsville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, ahock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel BREAST CANCER disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner that the death certificate be executed physician end s the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of) for use as USB 88 Part tt. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yee 2 ☐ No 3 Probably 4 ☑ Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24a. Wes an autopsy performed? page 2 1 ☐ Yea 2 No certificate t ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifical mpletely filled in by the funeral director, Be 25. Was case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)HOSPICE Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Panding 1 Yes 2 No Investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(a) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated. Medical 29a, Certifier (Check only one) To the I within 2 To the I complet 29b. Signeture and little of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D43725 2/15/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 31. Date filed (Month, Dey, Year) 32. Registrar's Signetare State FEB 1 7 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are pegible 1, 883

State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#10e PER F.H. G780 2-17-2000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Napoleon 13:30 00 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Johns Hopkins Baltimore Baltimore 6. Sex 1 M 2□ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Sept. 29, Birthplace (State or Foreign Country)
 NC • 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Days 246-40-7190 71 Yrs 1928 Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-1 show the Medical Examiner must be notified at Baltimore n/a Md. 1 □ No 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1217 N. Linwood Avenue 21213 USA 238 Funeral 'natural', or items . Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 11. Marital Status filed within 72 hours after 1 Yes Rive If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify Specify: African American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry il Hygiene. other then Elementary/Second College (1-4or 5+) ondary (0-12) Long Shoreman Rukert Terminal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked o Raliegh Crowell Oueenie unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 N. Linwood Avenue Baltimore, Md. 21213 19a. Informant's Name/Relationship (Type, Print) Ollie Crowell wife Department of Health a Important: If item 27 is any injury or other tra once. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Cremation 3 Removal from State Feb. 8 Baltimore, Md. Voshells Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Serves Licurisi 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediete Cause (Final myocardial infarction

Due to (or as a consequence of): disease or condition resulting in death) Examiner Dronary artery disease
Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be axecu Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown cardiomyopathy of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? My percholes tero lemia
25. Was also referred to medical 1 Yes 2 No al or Attending Physician: The safter death.

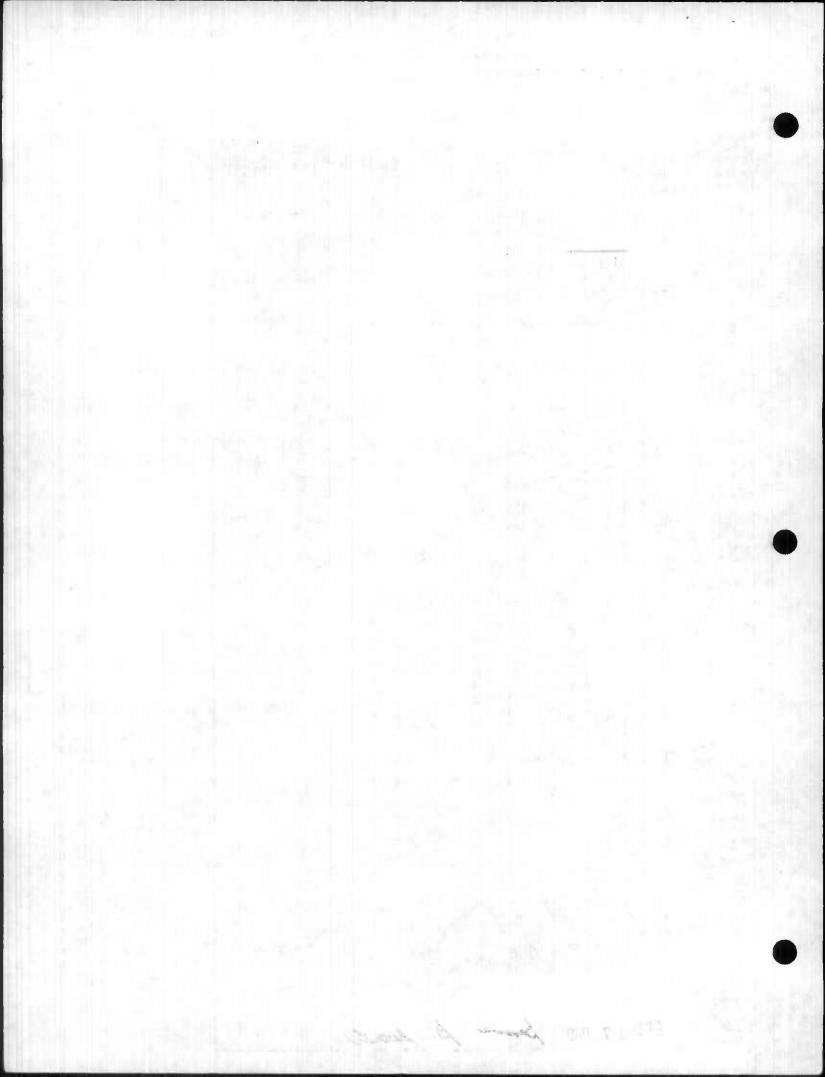
In Director: After this certificate ed in by the funeral director, pa 26. Piace of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending 1 Yes 2 No investigation 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D The Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and mannar as stated.

Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and mannar stated.

Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and mannar stated. 29a. Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and A.F. Chai M.D., M.S. who completed ceuse of deeth (Item 23a) (Type, Print) 30. Nama and address of pi m.D., m.s. 3509 Eastern Avenue Baltimice, MD. 21224 ChAi 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 4b,c 28a,c per phy. 6780 2/17/0 State of Maryland / Department of Health and Mental Hygiene U Amended Item#12#BerFHG780 2/23/2000 EW Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** Month Year C. Castle Gene /Medical FEBRUARY 13 2000 08:55 P.M. 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Localion of Death 4c. County of Deeth **Examiner** Baltimore GREATER BALTIMORE MEDICAL CENTER BALTIMORE If Under 1 Year 4-26-7149 6-24-7149 Deta of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Age (In yrs. lest birthday) **Funeral** 1 M 2 □ F Deys 68 Director Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 3426 Chesterfield Avenue 21213 USA Items 23a 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black. White, etc. 1 Never Married 2 Marriad 1 Yes 2 No If Yes, Give Yeer or Detes: "natural", or by Specify: ¾ Widowed 4 Divorced Black 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) than Elamantary/Secondery (0-12) Collaga (1-4or 5+) Hygiene. Fork Lift Operator Food Fair Warehouse 10th Grade marked other Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Sumeme) and Mental Williams Caroline Ferguson Joseph 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21218 19a. Informant's Neme/Ralationship (Type, Print) Health Andrea Bost or other tra 2604 Cecil Avenue Baltimore, Maryland Baltimore, 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stele XXBurlel 2 Cremetion 3 Removel from State Crownsville VA Cem. 02-22-2000 Crownsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenseis 22. Name end Addrass of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. antar tha moda of dying, such es cardiac or respiratory errest, Onset end Deeth Physician Immediata Ceusa (Final BRADYCARDIA diseesa or condition resulting in deeth) Examiner Dua to (or as a consequence of) Examiner HEART DISEASE ATHEROSCLEROTIC Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated events pue Due to (or es a consequence of): MELLITUS DIABETES 68760 Physician/Medicai thet initiated events resulting in death) Lest Due to (or as e consequence of): Box (Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o ۵ 1 Yes 25KNo 3 Probably 4 Unknown STAGE RENAL DISEASE Records, by 24b. Were eutopsy findings eveilable prior to Completed HYPERTHYROIDISM 24a. Wes en eutopsy performed? completion of cause of death? HYPERTENSION PULMONARY 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vital Be 25. Was case referred to medical examiner? 26. Placa of Daath (Check only one) Hospital: 1 Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2SNo 27, Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Affer Division Attending 1 Natural 5 Panding investigation death. 2/13/2000 1 Yes 2 Accidant after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) in by 4 Homicida 6 Hospital 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and mannar as steted.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end mannar stated. Medicai 29a. Cartifier within 24 hou To the Fune completely fi \$ 29b. Signeture title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 47051 30. Nama end eddrass of person who complated ceusa of daeth (Itam 23a) (Type, Print) NORTH CHARLES ST # 216 BACTIMORE, MD 21204 IOSE ALMARIO 6565 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State Registrar FEB 1 7 2000

DHMH 16 Rav 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 185 State of Maryland / Department of Health and Mental Hygiene

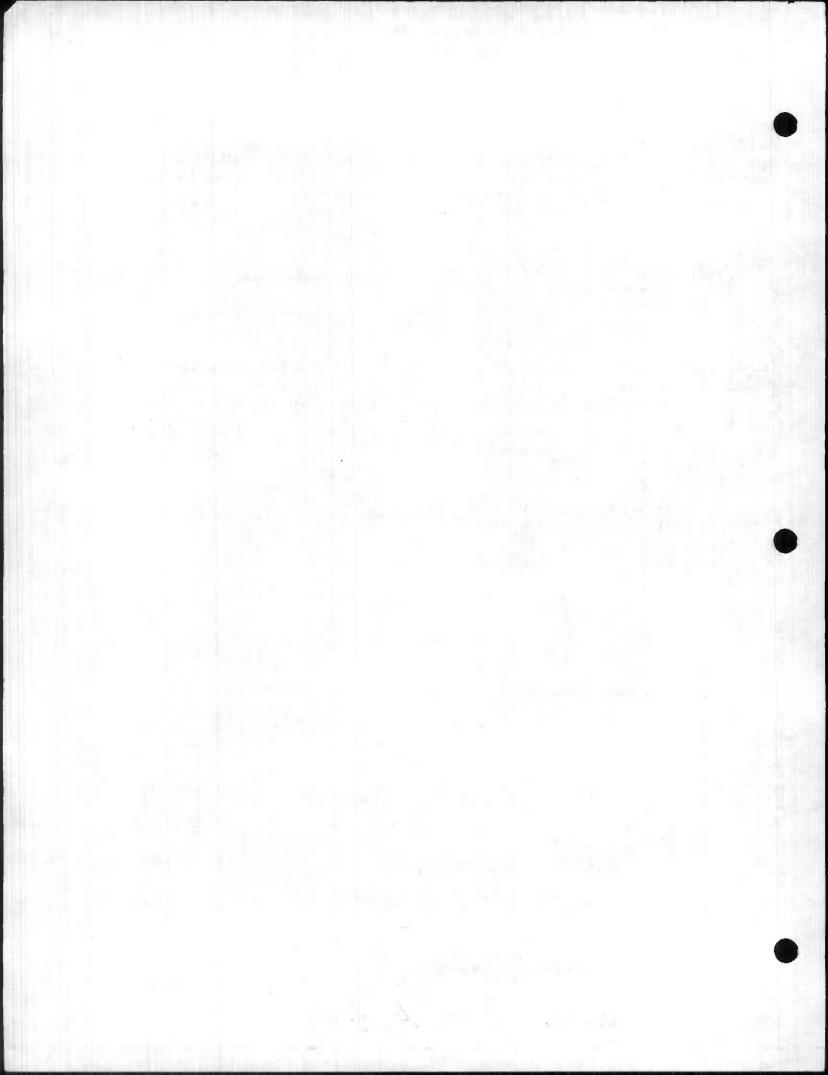
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d item 23a pt.	11, 27 per me 2/25/00 yg		Certif	icate of	Death		Reg. No.				
Physician /Medica	MICHAMO CHAMAD					2. Date of Do Month FEB	Dey 2000	Year 3. Time of Death			
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	10e. Street and Number		ALTIMOR	Of. Zip Code	224		10g. Citizen of What Country?				
lar death llama 23 DMC must	11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yas 3☐ No the Yes, Give Year or Detas:			224 Hispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)		e - American Indian, ck, White, etc.			
1 2121 ad within yolens. ner than	15. Decedent's Ed (Specify only highest grad Elementary/Secondery (0-12) 1 2 T H	ucation la completed) College (1-4or 5+)	life. DO	s Usuel Occu f of work done NOT use retire RTY C	during most of word) LERK		UNIVE	RSITY OF MD.			
yland ould be ill Mental H Mental H arbs out	17. Father's Neme (First, Middle, Last) PAUL W. CONN					RET WE	, Maiden Sumam ISS	θ)			
Baltimore, Mar- semil. Pages 1 and 2 and Separansmit of Health and reportant: if New 27 is many injury or other traum	19e. Informent's Nerre/Reletionship (7 CATHERINE TAYLO) 20e. Method of Disposition 1 Burial 2 © Cremation 3 Disposition 4 Donetion 5 Other (Specify	R/SISTER 20b.		OLDSP	ce)	AD, BAI	LTIMORE 20c. Location -	Stere, Zip Code) , MD. 21220 City or Town, Stata REL, MD.			
Physician /Medical Examiner	23a. Pert1. Enter the disease, or compshock, or heart feiture. List only of Immediate Cause (Final disease or condition resulting in death)	. ATHEROSCLEROT		ASCULAR I		c or respiratory e	orrest,	E MD 21224 Approximate Intervel Between Onset and Death			
68760, tiflicate be assected to physician and se the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	bDue to (or as e consequen	ce of):							
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. 5 . 2	Part II. Other algnificant conditions co	ntributing to death but not re	sulting in the under	tying cause gi	ven in Pert I.			ntribute to the cause of death?			
Records, P.O. The law requires that the site has been signed by the page 2 should be detached.						24e. Wes	an eutopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?			
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g Physician: The certificate near director, part of the certificate near director, part of the certificate near near near near near near near nea	NCXYes 2□ No	Hospitel: 1 Inpatient 2 Inpati	ER/Outpatient 3	BDOA Ot	her: 4 Nursing H		idence 6 Oth				
Division of Vital Re To the Hospital or Attending Physician: The Is within 24 hours after desith. To the Funeral Director: After this carificate he completely filled in by the funeral director, page Madical Cariffication	1 🖄 Netural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, ferm, street,	M 1	Yes 2□No	28f. Location City or To	(Street and Numb wn, State)	per or Rural Route Number,			
DIVISION To the Hospital or Attend within 24 hours after dest To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examine									
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State Registrar

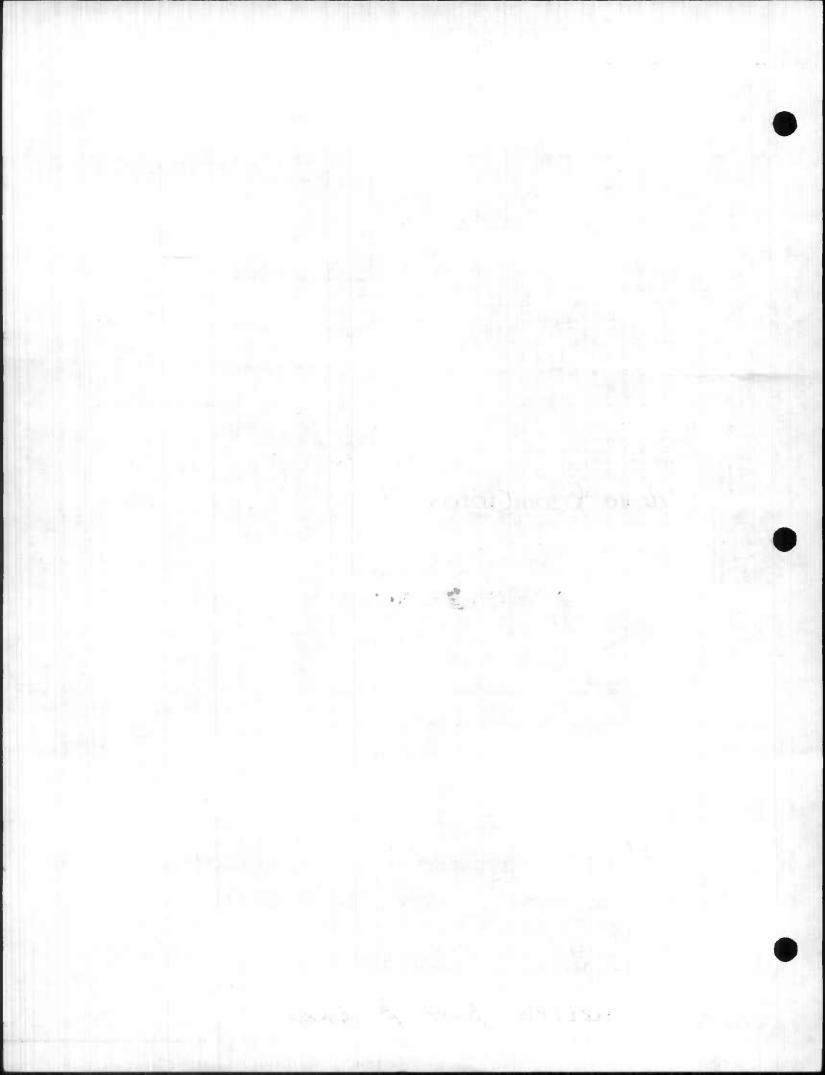
ed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



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to	Maryland	Baltimore		Ralti	more Cou	ntv					1 Yas 2 No
Director	10e. Street and No			I	indic du	10f. Zip Co	de		10g. Citizen of	What Country	7
9	7821 Perry	Road				21236			USA-	HONOURAS	
Funeral	11. Marital Status		12. Was Decedent Armed Forces?		S. 13. W		of Hispanic Origin's Cuban, Mexican, P	? (Specify Yes or N		ce - Amarican	
Dy ru		ried 2 Married 4 □ Divorced	1 Yes 2 N If Yes, Give Year or Dates:			Yes 2		oorto riican, atc./		ock, Whita, atc.	
per		15. Decedent's Edu	cation		16a. Decede	nt's Usual O	ccupation		16b. Kind of B	usinass/Indus	lry
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To	Isaac Cha	evez					Maria	Santiago			
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	Ignacio I	Chevez (Son)			7821 Pe	rry Roa	d Baltimo	re, Marylar	rd 21236		
	20a. Method of Dis	sposition	Removal from Ctat-	20b. P	lace of Disposi emetery, creme	tion (Name of tory or other	of r place)	Date		- City or Town	State
		5 Other (Specify)					bruary 17,2	0000	Marriott	sville.M	aryland
	21. Signature of F	uneral Service Licens	00	-			ddrass of Facility				
	Most	m thoo	aha Or	100	La: La	ssahn H	uneral Home	timera Mar	-11010	~	
	23a, Part 1, Entar	the disease, or compl art failure. List only o	ications that caused	the death	n. Do not enter	the mode of	dying, such as car	diac or respiratory	yland /1/ arrest,	JO	proximata
	snock, or ne	an ranure. List only o	ne cause on each in	ne.						Or	erval Between nset and Death
	Immediata Causa disease or conditi	(Final	1	A	a wal '		Engalla			1	
	resulting in death)	~	Acute 1	Due to for	CATO IC	auce ou.	rarct10	<u>()</u>		10/4	hours
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3	Part II. Other signi	ificant conditions con	ntributing to death be	ut not resu	ilting in the unc	lertying caus	e given in Part I.	23b. Dic	tobacco usa co	ontribute to 1h	e cause of death
	A	0						1	Yes 20 No	3 Probeb	ly 4 Unknow
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Completed by Physician/Medica	17. F1 .41	- I OF I HA						-		of dea	ith?
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	25. Was case refa axaminer?	/					26. Place of	Death (Check only	ona)		
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	27. Manner of Dea	th 5 Pending	28a. Data of Injur (Month, Day	y Year)	28b. Time of Injury	28c.	tnjury at Work?	28d. Describe	how injury occu	rred	
1	2 Accident	investigation				М	1 ☐ Yes 2 ☐ No	17			
on micanoli.	3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	28e. Place of Injubuilding, etc	ury - At ho c. (Specify	me, farm, stree ')	t, factory, of	fice	28f. Location City or To	(Street and Num own, State)	ber or Rural R	oute Number,
edicai C	29a. Certifier (Check only one)	1⊠ Certifying Phys	ner: On the basis of and manner sta	examinati	wledge, death o ion and/or inve	ecurred at the	he time, date and p my opinion, death o	lace, and due to the	cause(s) and m	anner as state , and due to the	od. a cause(s)
Me	29b. Signature.acc	d title of certifier	en ici illen illeri sta	ileu.		29c. Li	cense number		29d. Data sign	ed (Month, Day	v. Year)
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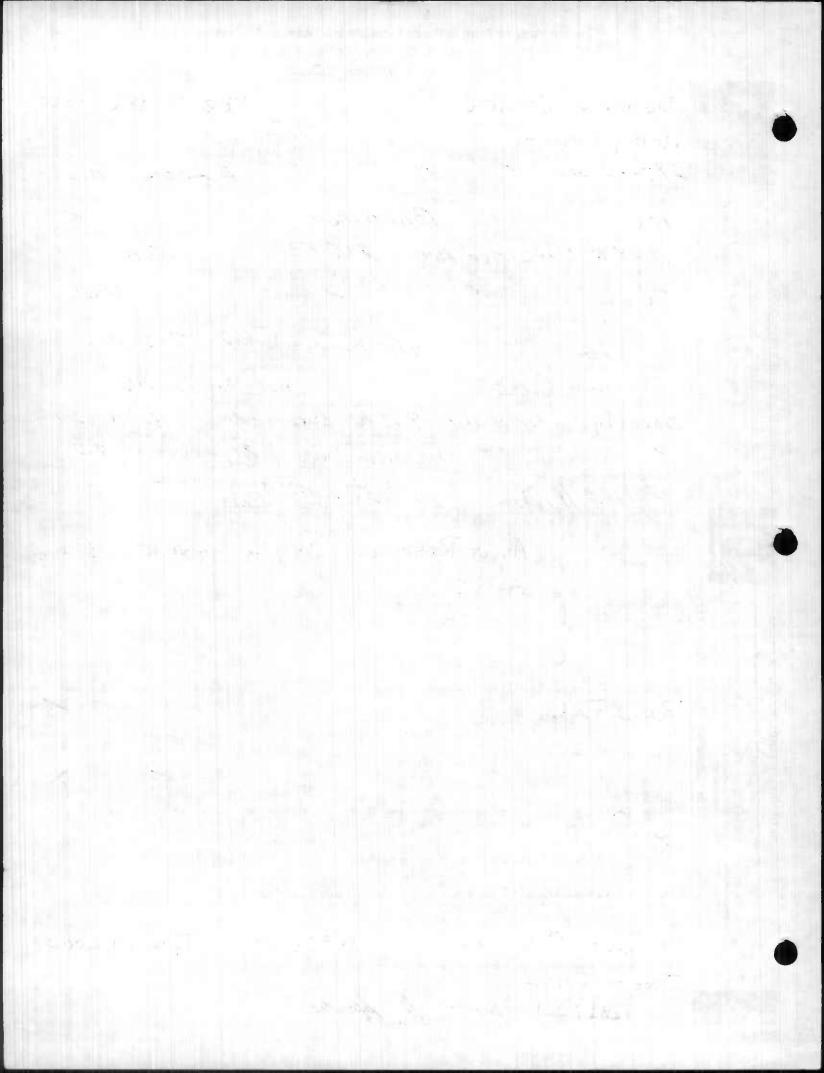
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 1887 State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last HONTH TEB **Physician** 1020 ENEEN CARTER 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner BACTIMORE MOSPITAL If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 10M 20F Days Hours Min 219-82-12 7 Yrs Director Usual Residence of Decedent the Maryland 10a. Stata 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Modical Examiner must be notified at BALtimore 1 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US Lurziner permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flema 23s any injury or other traumatic event. Its Manical Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Dever Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT,usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Eiementery/Secondary (0-12) Coilege (1-4or 5+) Worker Lndustry larehouse 12 18. Mother's Name (First, Middle, Maiden Sumema) 17. Father's Nama (First, Middla, Last) Dorothy)ames 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) urziner Are Balto MW 21213 08 ar ter Nother Dorothy 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Deuriai 2 Cremation 3 Removal from State Dundulk, me chell Come fern 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Test Night foreset to 163 f. N. Broad way funeral to 163 f. N. Broad way the second of IG 3 4 n Funeral Home **Physician** /Medicai immediate Cause (Fine) diseese or condition resulting in death) Examiner Examiner the attending physician and hed for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Nonknown P 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? been s completion of causa of deeth? 1 ☐ Yes 2 No 1 ☐ Yes > No i or Attending Physician: after death. I Director: After this certific director. 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1□ Yes 250No 1 Monpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1-Deatural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of cartifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COSTA) OSEPH

AH

State Registrar 31. Date filed (Month, Dey, Yeer) FEB 1 7 2000 32. Registrar's Signature

Sporks



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	State of Ma	aryland / Departi	ment of Hea	alth and Menta	l Hygiene

IUGH CRAWI	FORD	State	of Marylar				Health and N Death		giene Reg. No.		
	1. Decedent's Nama (First, Mi	ddle, Last)						2. Date of De			3. Time of Death
Physician	HUGH VANCE	TONNEADD	CD					Month FEBRUA	RY 6, 20)00	0955 AM
/Medical Examiner	4a Facility Name (If not institu MARYLAND GEN	ition, give street and nu ERAL HOSPIT	umber) FAL				4b. City, Town, or L BALTIMOR	ocation of Death	· ·		
Funeral Director	5. Social Security Number 249-42-1611	6. Sex	7. Age (In yrs. 66		If Under Months			8. Date of Bir 2 Month, Da	th Year)	9. Birthp	place (State or Foreign ENCE S.C
	Usual Residence of Decedent							1			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or frems 23s or 28e-f show sumatic event, the Medical Estandos must be notified at TO Be Completed by Funeral Director	MD 10b. Cou	nty N/A		ty, Town or Li LTIMO						1	10d. inside City Limits 1 1 Yes 2 □ No
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5 5 6	17. Father's Name (First, Midd	lle, Last)		, 510	71	2111	18. Mother's Nam				5.0000
0 5 -							KATIE I				
marked imatic ev	19a. Informant's Neme/Relette			19h Meili	ing Address	(Stree	et and Number or Rur		er. City or Town	State 7in	Code)
or trace	VANCINE CRAV		UGHTER				ST, BAL				
	20a. Method of Disposition			Plece of Dispo	osition (Name	ne of ther ple	ece)	Date	20c. Location - (City or To	own, State
T, or	1 Burial 2 □ Crematic 4 □ Donation 5 □ Other	on 3 LIRemoval from (Specify)	State /1	NT:	210	X		7-16-00	1	110)
Important: If It any Injury or ance.	21. Signature of Fushral Servi	l Zegl	2ies	4	600	LIE	FUNERAL I BERTY HGI	HTS AV		0.	MD 21207
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- H	27. Manner of Death	28a. Dete	Inpatient 2 S of Injury ofh, Dey Year)	28b. Time o Injury		8c. Inju	4 🗀 I TOUSHING I TO		dence 6 Other		<u> </u>
Director: After to in by the funeral prtification:	3 Suicide 6 □ Cou	ld not be	e of Injury - Ath ling, etc. (Speci	ome, farm, st fy)				28f. Location (City or To	Street and Number wn, Stete)	er or Rura	al Route Number,

Medical Certification: To Be Completed by Physician/Medical

or Attending Physicien: funeral director, this filled in by

To the Hospital or Attendir Within 24 hours after death. To the Funeral Director; A

29a. Certifier (Check only one) 29b. Signy

State Registrar

ure and titla of certifier

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

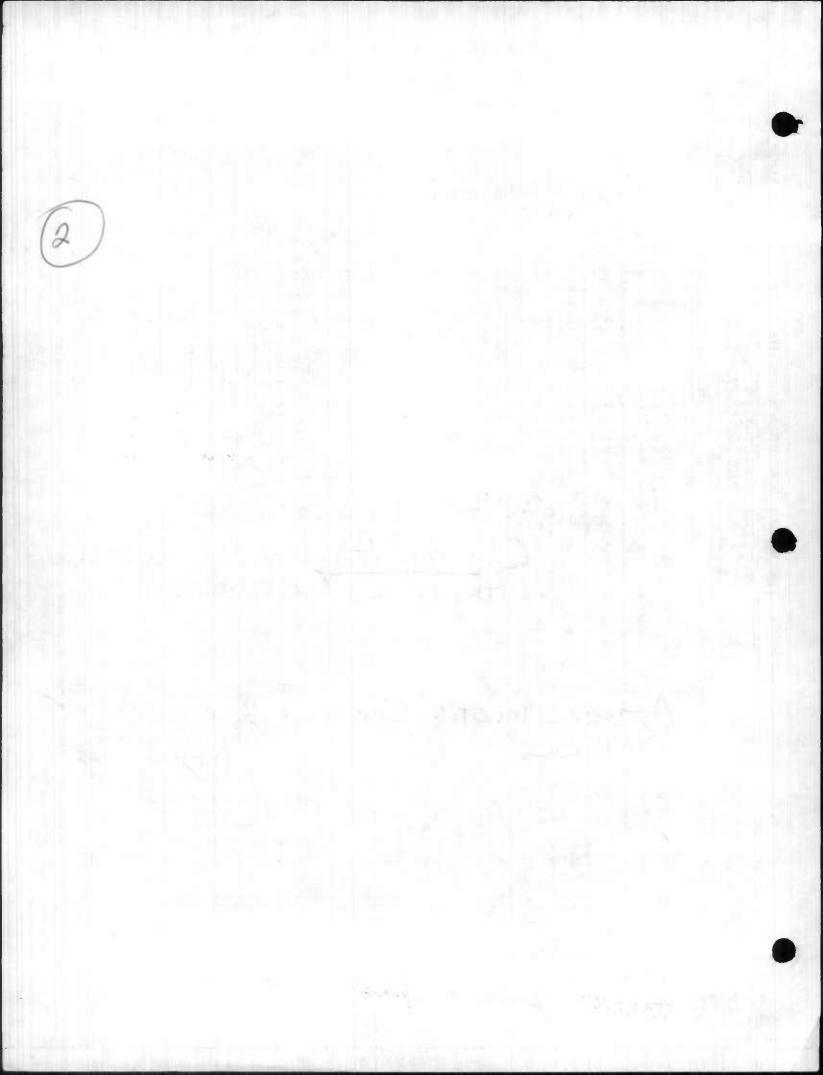
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number O.C.M.E.

29d. Data signed (Month, Day, Year) FEBRUARY 7, 2000

npleted cause of eath (Item 23a) (Type, Print)

Hopestrars Signature Francisco Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene' Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year **Physician** CARGO 09:53 AM WILLIS February 14 2000 /Medical BALTIMORE

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

AUG 30 1924 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL If Under 1 Year Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 20 F 228-36-6813 Yrs. Director Usual Rasidenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be nutthed at 1 Yes 2 No Funeral Director ALTIMORE 10e. Street and Number 10g. Citizen of What Country? 2113 UE USA 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No 1 Nevar Married 2 Married 1 Yas 2 No 21215-0020 Specify: BLACK þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry nd Mentel Hygiene. marked other than Elemantary/Secondary (0-12) College (1-4or 5+) 11 Maryland 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middla, Last) permit. Pages 1 and 2 should be filt Department of Health and Mentel Hy Important: if fem 27 is marked oth any Injury or other traumatic event potes. KNOWN AS GENE BXNUM MABELLE 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 4501 KATHLAND AVEBALTO, MD CARGO RNESTINE 20b. Place of Disposition (Name of comatary, cramatory or other place) CHURH, BEULAH LAND CEMETER 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 ☐ Burlal 2 ☐ Cramation 3 PRamoval from Stata 2-19-00 4 ☐ Donation 5 ☐ Othar (Specify) (IVOR 22. Name and Address of Facility /1000ELL 21. Signatura of Funaral Servica Licansea FUWERAL HOME 4600 LIBERTY HOGH'S AVE, BALTO, MIC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final · Ischemic Cerebral Vascular acciden disease or condition rasulting in death) Examiner Medical Certification: To Be Completed by Physician/Medical Examiner siclen and burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disaasa or Injury Dua to (or as a consequence of) Box 68760, physicien the buria that initiated evants rasulting in death) Last Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23h. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Hypertension of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was casa rafarred to medical axeminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 1 Matural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending 5 Panding invastigation death. 1 ☐ Yas 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - Al homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar completely (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year) Kaulu Weber, D.O. Intern February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maren Weber Sinai Hospital souls!

State Registrar

31. Date filed (Month, Day, Year)

2000

DHMH 16 Ray 6/95

32. Registrar's Signatur



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

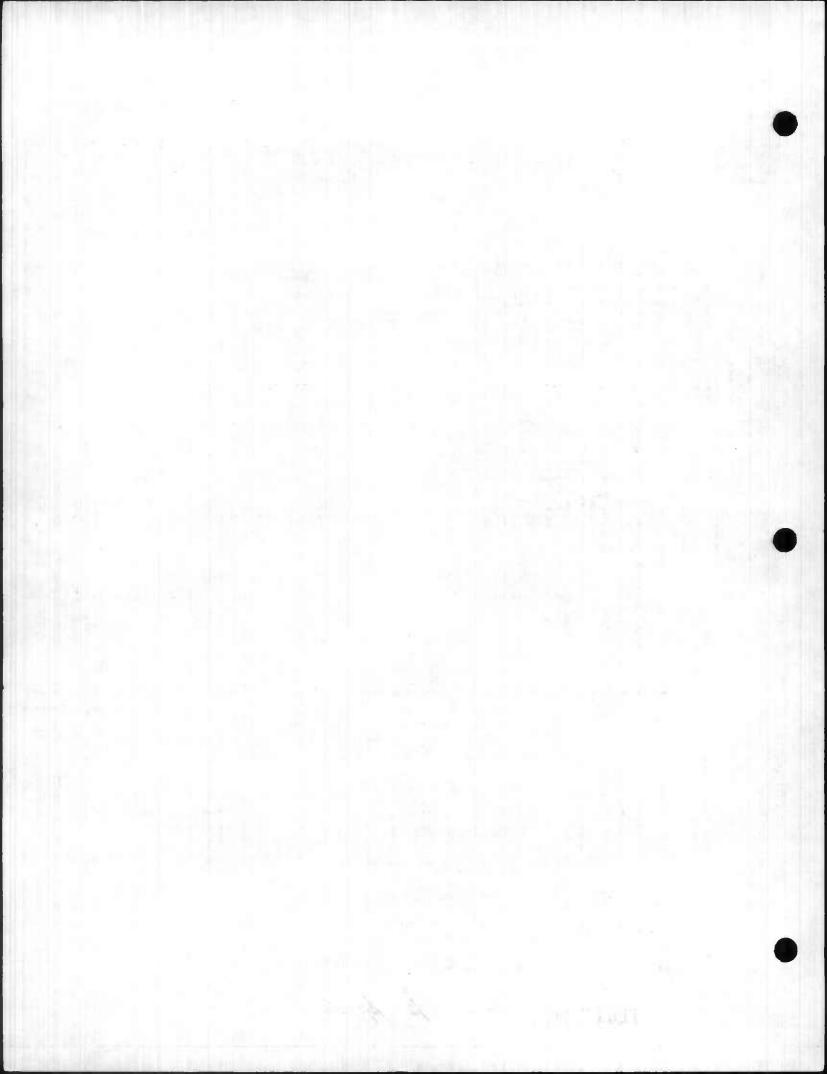
State of Maryland / Department of Health and Mental Hygiene U

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Joan Domfort February 16, 2000 10:00 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4604 Brava Court Washington Prince George H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
July 21, 1952 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) Funeral 1 M 2 XF Months Days Hours 47 225-78-6762 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits them 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Prince George Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4604 Brava Court 20744 USA Norms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Capariment of Health and Mental Hygiene. Introducent: if them 27 le marked other than "natural", or then any injury or other traumatic avanta 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent Travel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J. Stiles Roberta I. Cameron 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherman Domfort/Husband 4604 Brava Court, Ft. Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 DCremetion 3 ☐ Removal from State Baltimore Washington Cr. 2/17/00 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fleck Funeral Home, Inc. WICH LIGHTER 7601 Sandy Spring Road, Laurel, Maryland 20707 lactor disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical ARCINOMATOUS MENINGITIS Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burlal-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or es a consequenca of) The law requires that the death P.0. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ₺ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics impletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 45274. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENSINGTON, MD 20895. 10870, CONNECTICOT AVENUE 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State FEB 1 7 2000 Registrar

DHMH 16 Ray 6/95

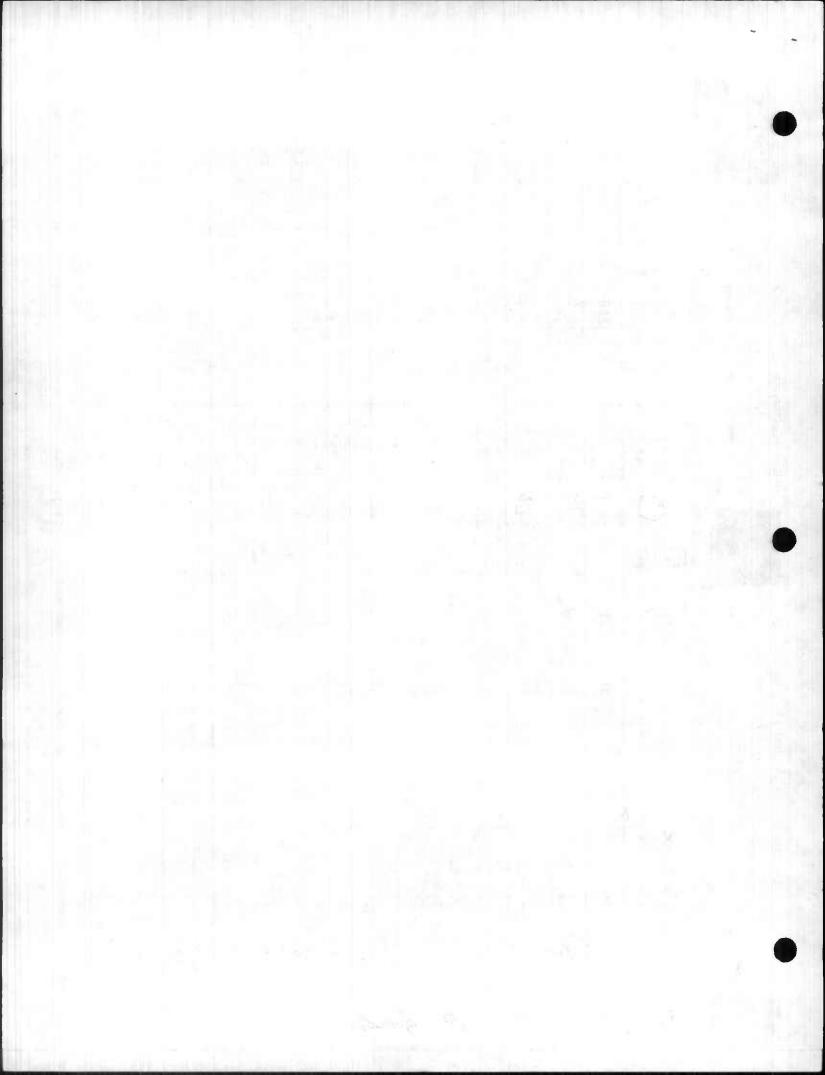


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State of Maryland / Department of Health and Mental Hygiene

		ate of Death		g. No.			
Physician	Decedent'a Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Tima of Death		
/Medical	Catherine Ann Dodson		February		3;25p1		
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	4c. County of Deeth	,		
	Fallston General Hospital	Fallsto		Harford			
uneral irector		ler 1 Year If Under 24 Hrs 8 Days Hours Min		1928 9. Birth	place (State or Foreign ntry) ryland		
Š to	10a. Stata 10b. County 10c. City, Town or Location			1.	10d. Inside City Limits		
be notified Director	Maryland Harford Belair			1 □ Yes 2 □			
		Zip Code L O 1 4		g. Citizen of What Cou United Stat			
it, or tame by Fune	1 Never Married 2\(\infty\) Married 1 Yes 2\(\infty\) No	bedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2 No Specify:	14. Race - Ameri Black, White, Specify: Wh:				
r, the Medical	Elementary/Secondary (U-12) College (1-407 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) Salesperson Levinson					
F O	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Sumame)				
To Be	John Henry Hickey, Jr.	Mary Edith Trishman					
Ę –	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Addr.	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
rtra	Santa Dodson - Husband 104 Mead	ow Road; Bela	ir, Maryl	and 21014			
€ I	20a. Method of Disposition 20b. Place of Disposition (lame of		Oc. Location - City or T	own, Stete		
2	1 140 bunal 2 Li Cremation 3 Li Hemoval from Stete	morial Park 2	/17/2000	Svkesville	. Maryland		
any injury or other traumatic avant, the Ma once	21. Signature of Funeral Service Licensee 22. Name Lorin	and Address of Facility g Byers Funer Liberty Road;	al Direct	ors, Inc.			
elevating prysician and liter use as the burlat-beneat clan/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(f):	7		Onset and Death (Imun)41		
	Part II. Other significant conditions contributing to death but not resulting in the underlyin	cause given in Part I.	23b. Dld tob	acco use contribute t	o the cause of death?		
0 -				a 2 No 3 Pro			
pleted			24a. Was an performe	ed?	fere autopsy findings vailable prior to ompletion of cause death?		
Sompl			1 ☐ Yes	2 No 1	□Yea 2□No		
Be G	25. Was case referred to medical	26. Place of De	eath (Check only one))			
10	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 ☐ Residen	ice 8 Other (Speci	(y)		
	27. Manner of Death 10 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	v injury occurred			
ed in by the funer Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fect building, etc. (Specify)	ory, office	28f. Location (Stre City or Town,	eet and Number or Rur State)	at Route Number,		
Funer taly fill fical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurr one the basis of examination end/or investigation and manner stated.						
Med Med		9c. License number	290	d. Date signed (Month,	Day, Year)		
10	NM_ MD	134652	E	home 13	2000		
7()	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Huswill & North Auny	D34652	Dia Mu	I land	11114		
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	x	711 / 190	7	10.		

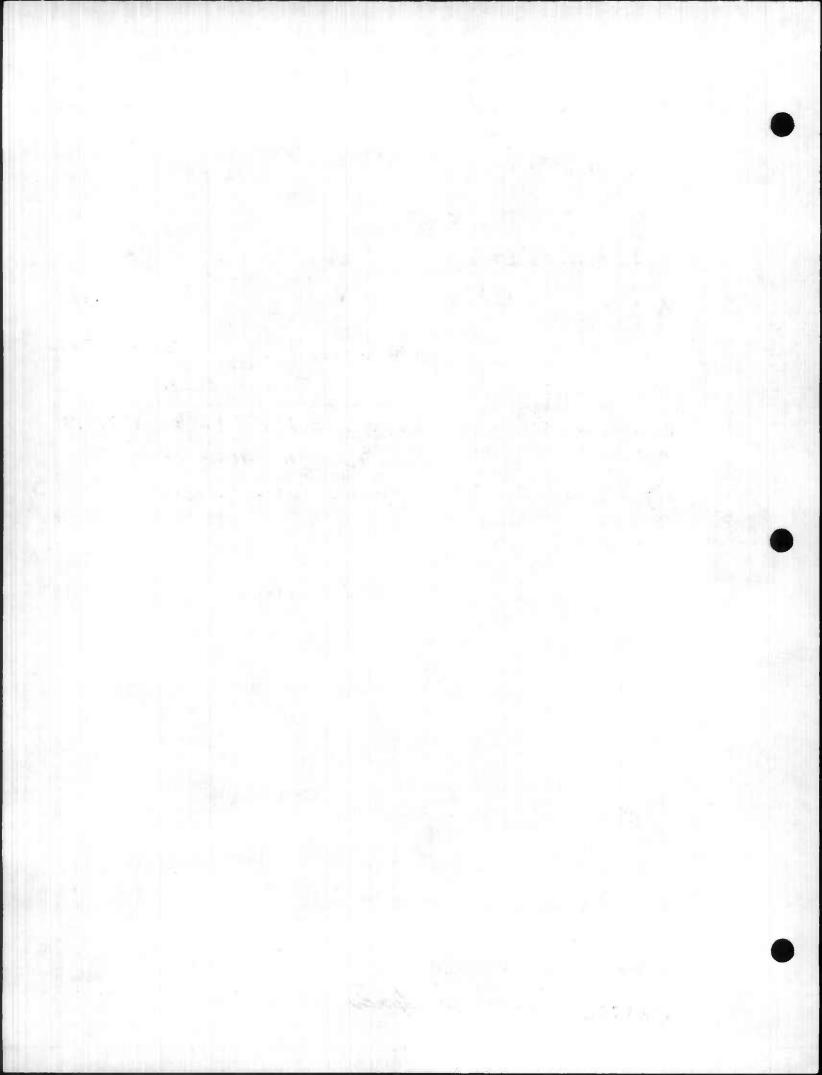
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State of Maryland / Department of Health and Mental Hygiene 0 4892

Physician							Death			Reg. No.		
Physician	1. Decedant's Name	a (First, Middle, Las	1)	,					2. Data of De Month	ath Day	Year	3. Time of Death
/Medical	KOXIG	2 Dr	edde	$\sqrt{}$					2	12	2000	9 h. m
Examiner	4a Facility Name (II						4b. City, To	wn, or Loc	ation of Death	4c. County		11.12
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Funeral	5. Social Security N			Aga (In yrs. la	st birthday)	If Under 1 Yea	r If Undar	24 Hrs.	8. Date of Bir (Month, Da		9. Birthpl	aca (Stata or Foreign
Director	218 07	9503A 11	□M 200 F	99	Yrs.	Months Day	s Hours	Min.	(Month, Da	y, Year)	Count	md
	Usual Residence of	Decedant							-5/			1110
dang #	10a. Stata	10b. County		10c. City,	Town or Loc	ation					10	d. Inside City Limits
Many Many	md	NIA		BA	LTO.							1 Yes 2 No
the contract	10e. Street and Num				470	10f. Zip Code				10g. Citizen of	What Count	n/2
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72 hours after death with the Manyland natural; or items 23s or 28s-f show deat Exercises must be notified at seed by Funeral Director	633	Misqui	1 57	Francis II.C	10.14	1	3 Z		M. Van as Na		e - Amarica	an Indian
D E	11. Marital Status		12. Was Deceder Armed Forca	s?	. 13. W	as Decedent of Yas, specify Cu	ban, Mexicar	n, Puarto R	lican, etc.)	Bla	ck, White, e	
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up up	Elementary/Seee	ndary (0-12)	College (1-4c	or 5+)	lifa. D	O NOT use retir	ed)			SIN	21	Hosp
filed within Hygiene. there then and, the then and, the then and, the then and, the then are Complete.	100	2			140	useke	EPING	2		2111	n'	P
d oth		(First, Middle, Last)							_	Maiden Suman	na)	
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	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate interval Between											
Physician	shock, or haart failura. List only one cause on each line. Interval Batween Onset and Death											
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an cermicate be executed attending physician and for use as the burial-transit staryMedical Examir	The full milities and execute		d	Dua to (or a	is a consequ	ence of):						
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aw requires that the death is been signed by the atter 2 should be detached for u pleted by Physiciar	resulting in death) L	Last	d				n Part I		1 🗆 24a. Was perfo	Yea No No an autopsy ormed?	3 Prob	ably 4 Unknown ore autopsy findings illable prior to applation of cause leath?
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2, Date of Death 3. Tima of Death **Physician** Byrd 11.45 AM IMogene DougLAS 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2800 Buloney Valley of Balte Stelln 7. Age (In yrs. last birthday) MARIS If Under 1 Year | If Under 24 Hrs. | 8. Data of Firth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (Stata or Foraign Country) **Funeral** Days 1 M 2 KF Months 86 40 5084 Director Usual Rasidance of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Balto Md 1€ Yes 2 No Director N. A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4107 RALeigh 21208 4.5. A Be Completed by Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 3 No If Yas, Giva Year or Detas: 14. Race - Amarican Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married Black "netural", or 1 ☐ Yas 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If tem 27 is marked other than Elemantary/Secondary (0-12) College (1-4or 5+) Balto C.TY Teacher MASTER'S Degnel 18. Mothar's Neme (First, Middle, Maiden Sumema) Maryland 17. Fathar's Nama (First, Middle, Last) Bynd HUNTING Ton MAMIC PIETY 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Roleigh Rd Balto. Md. 21208 4107 BEVERLY GLOYER 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Important: If it any injury or c 1 Burial 2 Cramation 3 Removal from State 4 Donetion 5 Other (Specify) 2/1/00 permit. Page Department arbutus mem PIT 21. Signature of Funarel Service Licensee 22. Nama and Addrass of Facility Locks Ports. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardia shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Finel disease or condition rasulting in death) /Medical BREAST CANCER 2 years Examiner Due to (or as e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, it any, leading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of): US0 85 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas X No 1 Yas 2 No or Attending Physician: 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence SCOthar (Specify) HOSPICE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending invastigation 1 Natural 2 Accident death. 1 Yes 2 No s after death 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida within 24 hours a Hospital 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Certifier completely (Check only one) To the I 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 2/14/00 D43725 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

Registrar **DHMH 16 Rav 6/95**

State

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Douglas

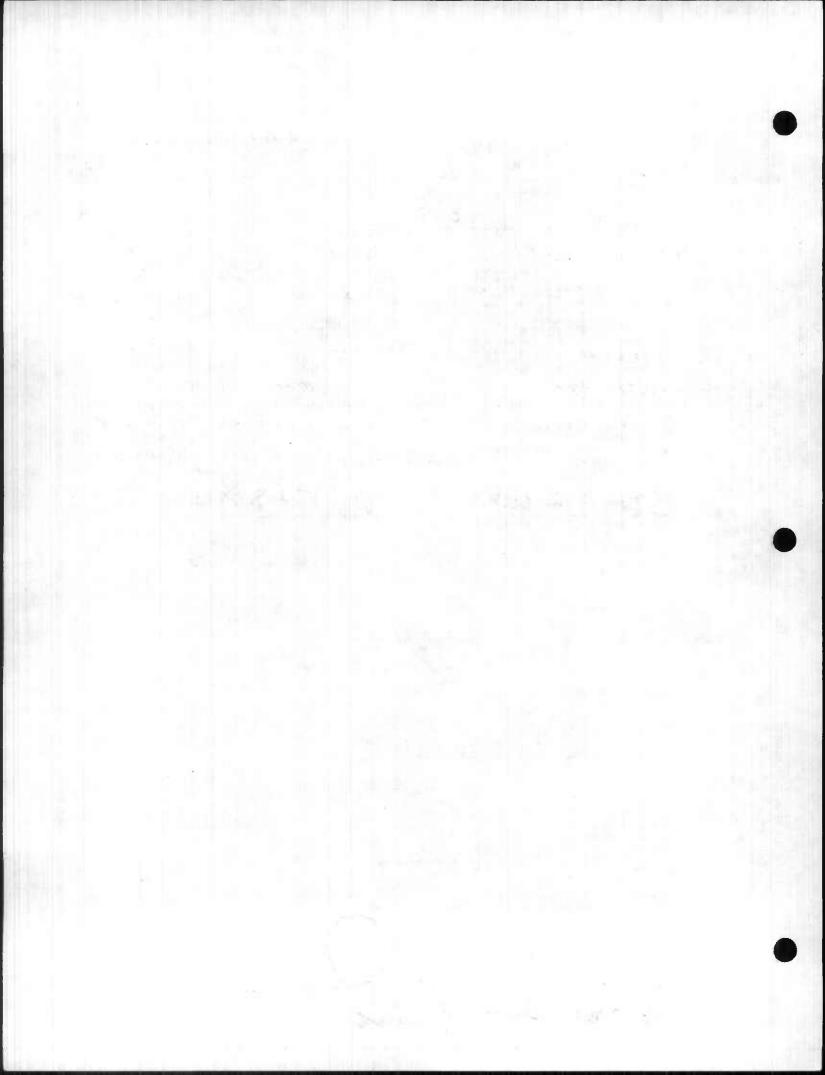
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Division of Vital Records,

Baltimore,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 16a, 16b, 17 State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G780 2/24/00 yg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month **Physician** Howard 2051 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMARE MARYLAND UNIVERSITY SALTIMORE CITY C174 9 6 | H Under 1 Yeer | H Under 24 Hrs. | 8. Deta of Birth (Month, Day, Year) | 3/3/1932 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1/ M 2□ F 36-6665 Director VA Usual Residence of Deceder the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits - NOW Peges 1 and 2 should be filled within 72 hours efter death with the Maryle neat whental Hyglene.
This if fear 22 I emerked other than 'natural', or flama 23a or 28af ehow mix if them or 21 emerked other than 'natural', or flama 23a or 28af ehow mix or other traumatic event, in the death is the status or mix as nothes. Md. ty⊠Yes 2 No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 547 Mosher Street Funeral 21217 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Bleck, Whita, etc. 1 Never Married 2 Married specity: Black Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Construction Elementary/Secondary (0-12) College (1-4or 5+) Handy Man pipe Layer 12 Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Howard Davis Sr. H-ward Davis St. Viola Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Davis 547 Mosher Street Baltimore Maryland 21217 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from Stete permit. Pege Department of Important: if any injury or paca. 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 2/16/00 Arbutus Maryland 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 21. Signeture of Funeral Service Licensee 1300 Eutaw Place Baltimore, Maryland 21217 Ces 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart feiture. List only one cause on each line. Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Cadiac Arrest Examiner Due to (or es a consequence of) Examiner brain sician end buriel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) physician the buriel Box 68760. atheros(tenos)s Physician/Medical Due to (or as e consequence of): for use es signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy lindings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? pege 2 : 1 Yea 2 No 1 ☐ Yes 2 ☑ No of Vital or Attending Physicien: 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannet of Death 28a. Data of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation ve Hoepital or Attending in 24 hours efter death. The Funeral Director: After pletely filled in by the fur 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar South

22

32. Registrar's Signature

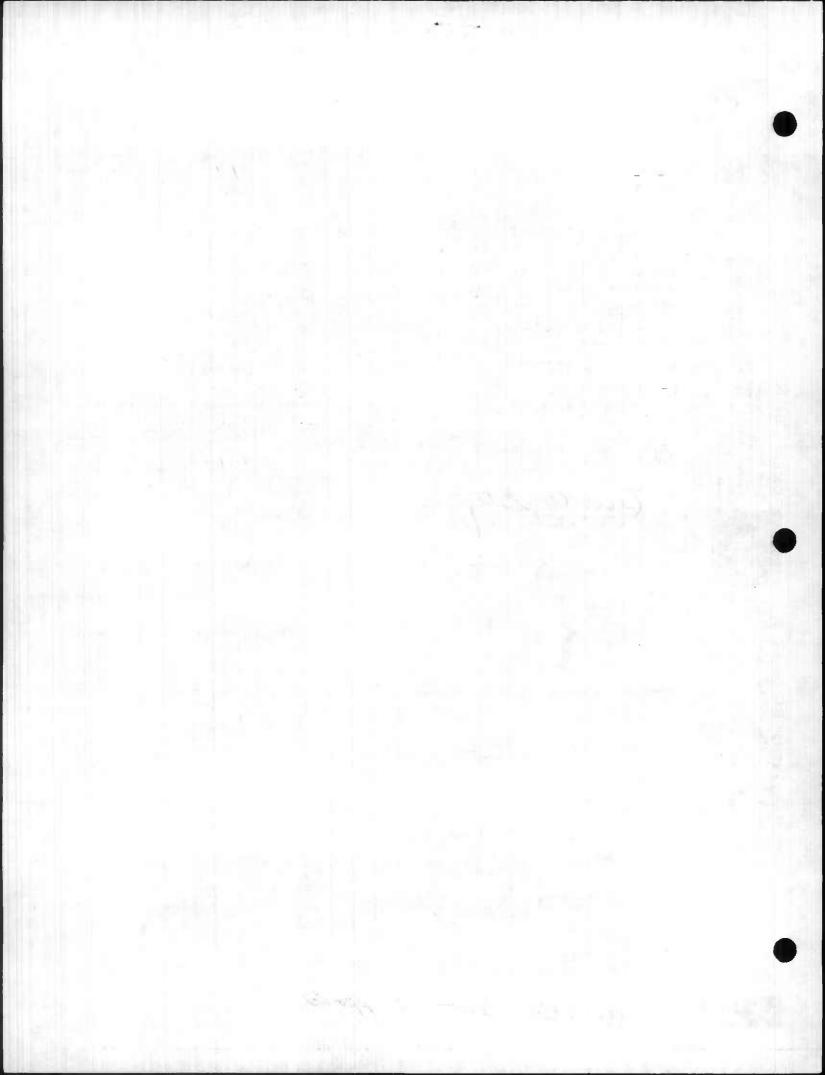
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

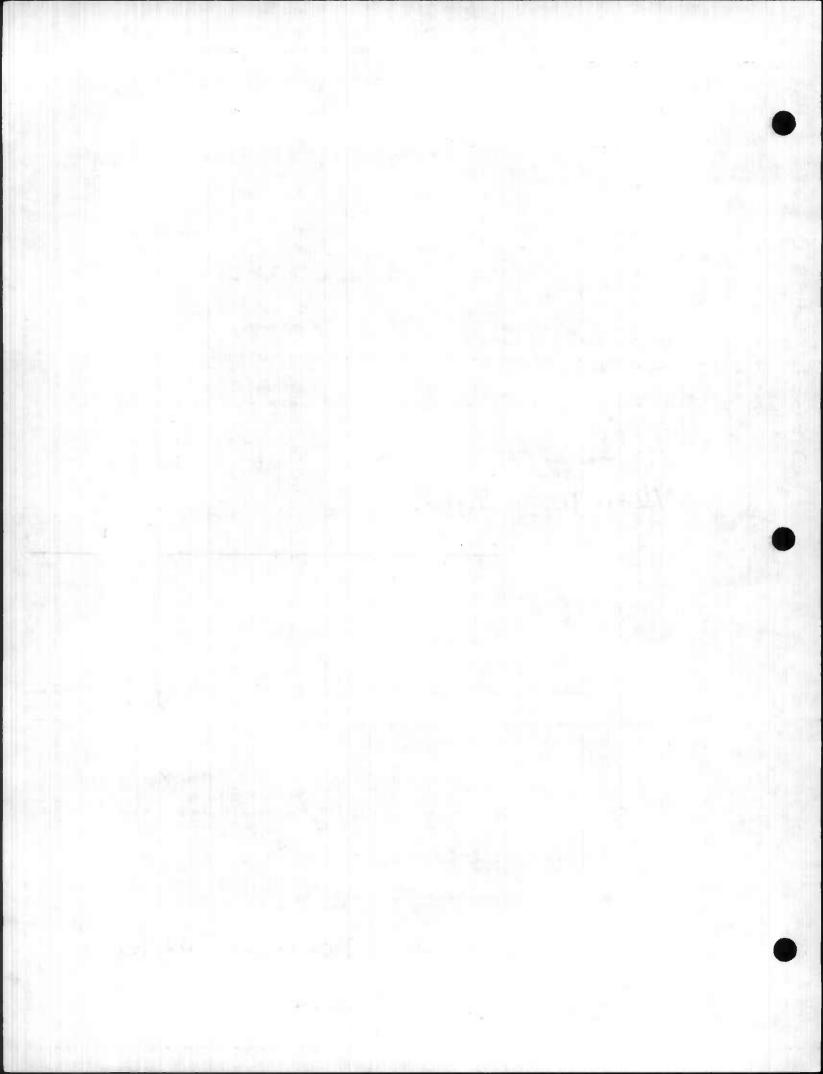
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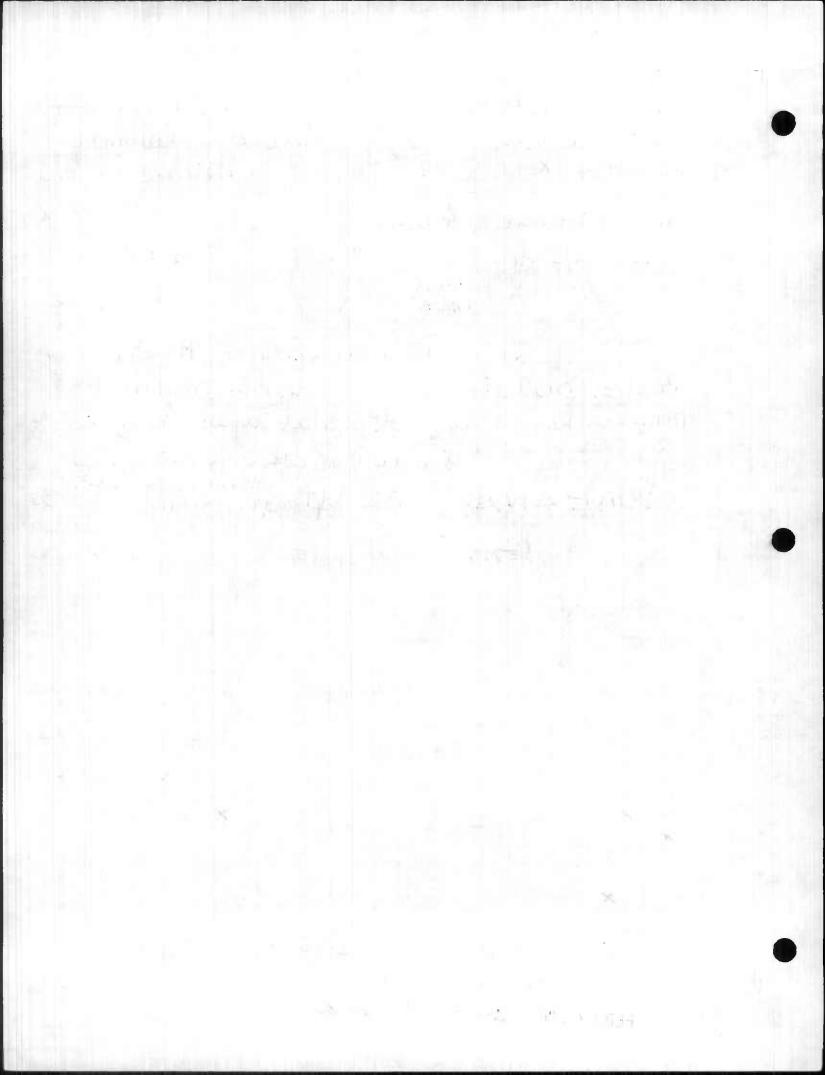
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	/Medical	CHARIS R. DIEGEL						8,200	0 5:40 A			
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Maryland 21215-0020	s 1 end 2 should be filled v s 1 end 2 should be filled v fem 27 is marked other it other treumatic event, at To Be Col	19a. Informant's Name/Relationship (Type, Print)			et and Number or Ru		3.77					
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	certificate be executed rightly sician and ise as the buriel-trensit	SUBARACHNOID HEMORRHAGE Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated avants Due to (or es e consequence of):										
_	EX PER SX											
9	a principa	Cause (Disaase or Injury										
68760	certificate be iding physicia ise as the bur	rasulting in death) Last	(or as a consequar	nce of):								
9	A Se						i					
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Œ	v requires that the deeth been signed by the atter should be detached for u	Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death part II.										
C	tha d y the ached	Part II. Other eignificant conditions contributing to death but not ra	asulting in tha unde	arlying ceusa (given in Part I.	23b. Did	tobacco use co	intribute to ti	he cause of death?			
C	Ph stay					1	Y00 2 NO	3 Proba	bly 4 Unknown			
Division of Vital Records	d bid					24a. Wa	s an autopsy		autopsy tindings			
Ö	et sperie					perl	ormed?	comp	able prior to pletion of cause			
a	The law requires the sate has been spage 2 should Completed						,	of de	ath?			
00	The page					10	Yes 200	101	Yas 2 No			
TO STATE	e o'. o	25. Was casa rafarred to medicel			OS Diego of Dee	th (Chaok onto	anal .					
5	Physician: The law rithis certificate has ral director, page 2 i. To Be Comp	axaminer? Hospital:			26. Place of Dea		- 1	-				
-	hysic con his con liding and direct To	1 165 20 NO 1 1 Inpatient 2L	☐ ER/Outpatient	3LI DOA	4 U Nursing H		idence 6 Oth					
-	ding Phys. After this funeral d	27. Mannar of Death 28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. In	jury et lork?	28d. Dascribe	how injury occur	rred				
C	of for	1 Netural 5 Panding (Month, Day Year) 2 Accident invastigation	,		Yas 2 No							
V.	To the the	3 Suicide 6 Could not be One Place of John Atl	home form street	factory offic	•	28f Location	(Street and Num	her or Rural F	Route Number			
- 2	lal or Attending Pris after death. al Director: After ted in by the funers Certification:	4 Homicide datarmined building, atc. (Spec	cify)	i, idolory, omo		City or To	wn, Stata)					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp											
	hound hound	29a. Certifier 1 Certifying Physician: To the best of my kn	nowledga, daath o	ccurred at tha	tima, data and place	, end dua to the	ceuse(s) and m	anner as stat	ed.			
	ne Hospi ne Fune pletely fil	(Check only 2 Medical Examiner: On the basis of examination and manner stated.	nation and/or invas	tigation, in my	opinion, daath occu	rred at the time	, date and place,	and due to th	ne cause(s)			
	Me di di	29b. Signature and title of codifier		20c Lico	nse number		29d. Date mgry	Ct /Month Da	ev Vesel			
	F 3 F 8		A	250. 2108	205.6	1-7	200.00	- 7				
	,	(ayan) (a)	MA	V	003411	5/	04/3	24/5	00			
	10	30. Name and address of person who completed ceusa ot death (Ita	am 23a) (Type Pri	int)		-	/	3/				
	4		N. CHAI		ST. 1	TOWSOI	J. MD	212	04			
				1		00001)	01/04				
	State	31. Data filed (Month, Day, Year) FFR 1 7 2000 32. Registrar's Sign	nature	1 40	acks							
	Registrar	LEDI I COOL	/	1.								

Registrar **DHMH 16 Rev 6/95**



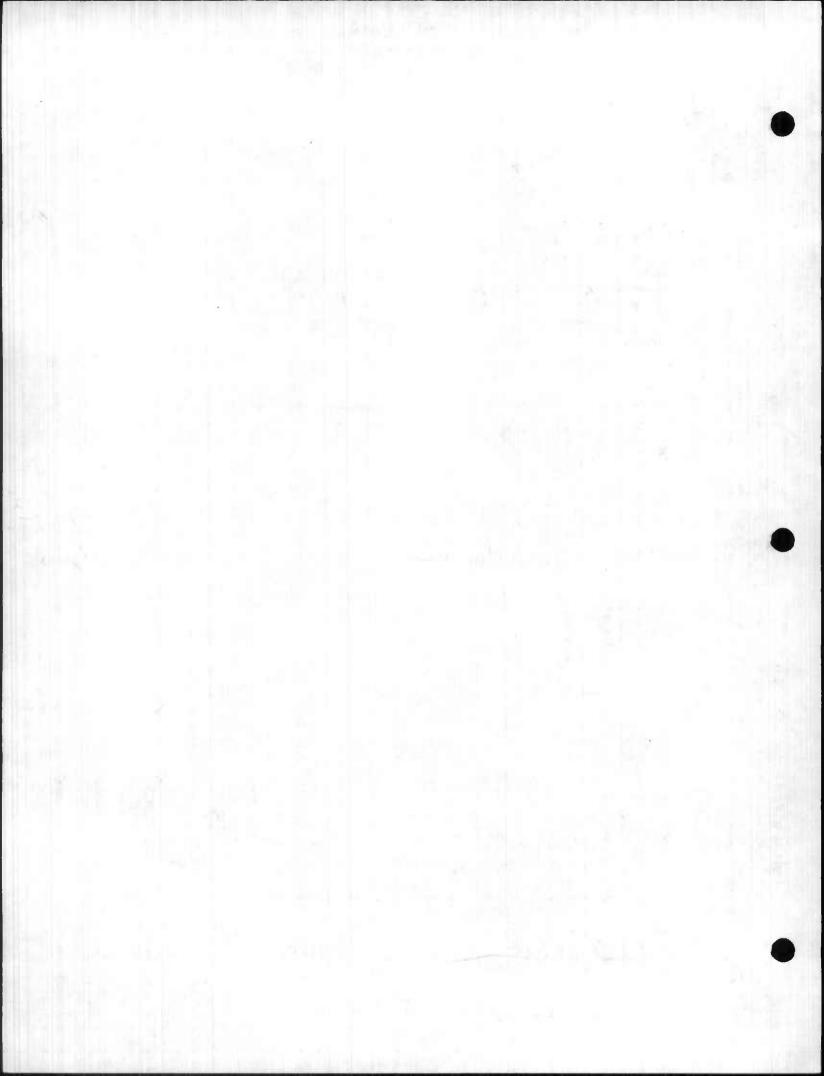
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AMENDED	ITEM #3 PER	MD G781 3/9/2000 AH Certificate of Death	Reg. No.	
	Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death
	/Medical	KRYMOND DOUGNETTY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or L	2/10%	2000 2354
	Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or L Around	ocation of Death 4c County	Limaco
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. Jast birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Gountry)
	Director	Usual Residence of Decedent	412911922	Maryland
	enylenc ehow des	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	r 28a-f ehow Inditied at	10e. Street and Number 10f. Zip Code	10g. Citizen of V	1 Yes 2 No
	be filed within 72 hours efter death with the Meryland tal Hyglens. 4 other than "satural", or frame 23s or 28s-f show event, the Medical Enancies must be noutred at event, the Medical Enancies must be noutred at Be Completed by Funeral Director	1012 Leeds Ave. 21227	Unite	a States
	Hems Derm	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent of Hispanic Origin? (Sr. Married 1) Never Married 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Pican, etc.) 14. Rac Blac	a - American Indien, ck, White, etc.
21215-0020	ours of	3 Widowed 4 Divorced Year or Dates: 12/16/45 1 Yes 2 No Specify:	Specify	White
15-0	led within 72 ho byglene. Nor then "naturn it, the Hedgell Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupation (Give kind of work done during most of work lifet DP NOT use retired)	16b. Kind of Br	usiness/Industry
212	Hied within Hygiens. other than end, the Head	Elementary/Secondary (0-12) College (1-4or 5+) Fei J Service Engin	eer Manu	tachring
pue		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	no (First, Middle, Maiden Suman	10)
Maryland	d 2 should be th end Mental 7 is marked or traumatic eve	19e. Informent's Neme/Relationship (Typis Print) 19b. Meiting Address (Street and Number or Ru.	ral Route Number, City or Town,	State, Zip Code)
	D = Z =	Marie Louise Paughertz daughter 2035 Sherlock He	dmesSt. Elders	burg MD21784
Baltimore,	272	20s. Method of Disposition 20s. Place of Disposition (Name of cemeter), cremetory or other place)	Date 20c. Location -	City or Town, State
altin	프 본 본 존 .	4 Donation 5 Other (Specify) Wood Quin I NOM PUTA to 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. M.	XI MO EUSTON	Have that
m	Depart impo	Man A Milde 1328 Soldwison	ing Rd. Arbit.	15Mb 21227
Tie.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physiclan /Medical	Immediate Cause (Final disease or condition METASTAT) C LUNG CANCER		6 MONTHS
	Examiner	resulting in death) Due to (or as a consequence of):		10 1001111
	licate be executed physician and a the burdel-transit addical Examiner	b		
90,	ate be executed thysician and the burlet-transit dical Examir	if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		
68760,		that initiated events		
Вох	attending for use	d		
0.	the deched to th	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.		ntribute to the ceuse of death?
٠, ح	s that is med by e dete		1 ☐ Yee 2 ☐ No	3 Probably 4 Unknown
Division of Vital Records, P.O.	clan: The lew requires that the deeth certificate be exa erificate has been signed by the attending physician a ector, page 2 should be deteched for use as the burlet- Be Completed by Physician/Medical Ex		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause
Rec	has b ge 2 st		154	of death?
Ta	an: The rtificate stor, pa	25. Was case referred to medicat 26. Place of Dee	1 ☐ Yes 2 No	1 ☐ Yes 2D No
> 50	this o		ome 5 Residence 6 Oth	
on	Attending Physician: ordesth. ector: After this cartification; the funeral director, iffication: To Be (27. Manner of Death Waturat 5 Pending (Month, Day Year) Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? Injury M 1 Pes 2 No	28d. Describe how injury occur	red
N N	re Atter ter des restor n by th	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,
Ω	ours of ours of filled in	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and ma	anner as stated
	To the Hospital or Attending Physician: The iew requires that the deeth cerwithin 24 hours effer deeth. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be deteched for use Medical Certification: To Be Completed by Physician/M	(Check only and Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occur and manner stated.	rred at the time, date and ptaca,	end due to the cause(s)
	To the Com	29b. Signaturo and title of certifies 29c. License number 29c. Lic		d (Month, Dey, Year)
	modo	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	FEB I	2,000
_	A. A		PALTIMORE Y	ND 21229
	State Registrar	31. Date filed (Month, Day, Year) Specific Signature Specific Signature Specific Signature		
		I LD I I I I I I I I I I I I I I I I I I		



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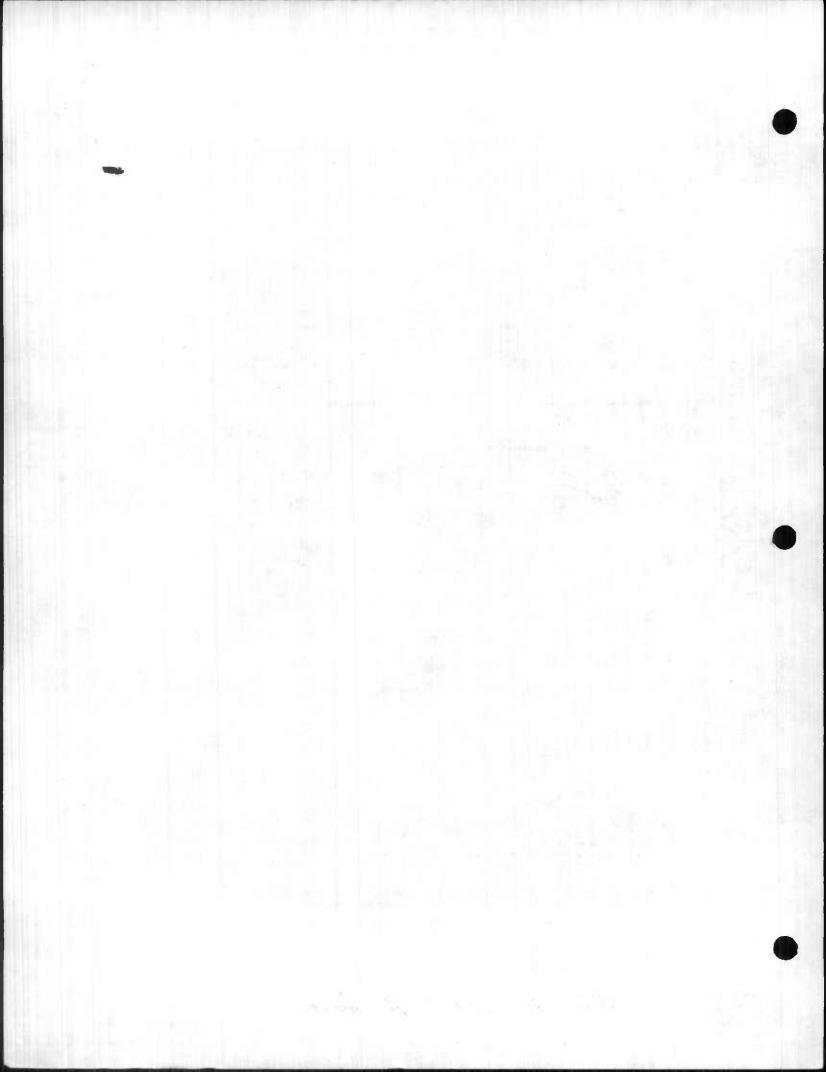
							Cei	rtifica	te of	Death			Reg. No.				
			1. Decedent's Name (Fit									2. Date of De	eath			3. Time o	of Death
	Physici		Ethel L.	Ethrid	ge]	Month	1 6	. 2	000	1:1	0 am
	/Medic Examin		4e Facility Name (If not	institution, give	street and n	um <i>ber)</i>				4b. City, To	wn, or Loc	ation of Deat		County of			
4	LAdillit	161	8122 Long	moint	D.d.					Dund	0 1 10		D	-14			
_	Funeral		5. Social Security Number			7. Age (In yrs	. last birthday)	If Unde	er 1 Year	Dund If Under	24 Hrs.	8. Date of Bir	th B	alt	imor		or Foreign
н	Funeral Director		219-26-91	1	□ M 2/2 F		Yrs.	Months	Days	Hours		8. Date of Bir (Month, Di			_		or Foreign
	_		Usual Residence of Dec			60						lov 22	,19	39	Md	•	
	Man Man		10a. State 10b	. County		10c. C	ity, Town or Lo	cation							10	d. Inside (City Limits
	Man A	ō	Md. F	Baltim	0.77.0		D	1-								1 ☐ Yes	2 No
	28 5	9	10e. Street and Number	Dartill	ore		Dundal		p Code				10g. Citi	zen of W	hat Count	ry?	
	With the same of t	₫	8122 Long	moint	DA			21	222								
	after death with the Marylan or Items 23s or 28s-f show miner must be notified at	Funeral Director	11. Marital Status	point		cedent Ever in t	U.S. 13.1		222 edent of	Hispanic Ori	gin? (Spec	ify Yes or No	USA	14. Race	- America	in Indian.	
	To the second	F	1 Never Married	21X Merried	Armed F		,	Yes, spe	ecify Cul	ban, Mexican	, Puerto F	lican, etc.)			c, White, e		
21215-0020	within 72 hours after death with the Manyland ene. than "natural", or frems 23s or 28s-4 show he wedess Exemples must be notified at	by	3 ☐ Widowed 4 ☐		If Yes, G	ive"		1 🗆 Yes	200 No	Specify:				Specify:	Whi	te	
ŏ	should be filed within 72 hours nd Mental Hygiene. marked other than "natural", imatic avent, the Medical Ex-	8	15.	Decedent's Ed	ucation	22111	16a. Dece	dent's Use	Jal Occu	pation		-	16b. Ki	ind of Bus	siness/Ind		
2	in 7	Completed	(Specify or	nly highest grad	de completed		(Give	kind of w	ork done	durina mos	t of workin	9					
27	A Page	E	Elementary/Secondary		College	(1-4or 5+)							UAW	Loc	cal	738	
	ould be filed v Mental Hygie arked other t atic avent, th	0	12 yrs 17. Father's Name (First	, Middle, Last)			Secre	tar	У	18. Mothe	r's Name	(First, Middle					
au	od be	o Be	Charles H	locker						B.f.		Coto					
Maryland	should ind Men ind Men imerke	٩	19a. Informant's Name/I		vne Print)		19h Mailir	on Address	s /Strae			Getne Route Numb		v Town	Stata Zin	Code)	
₹			William E			Shand						undal					
a ·	1 and Health am 27	1	20a. Method of Dispositi		ge ma.	20b.	Place of Dispo	sition (Na	me of				-		City or Ton		
Baltlmore,	permit. Pages 1 and 2 Department of Health 4 Important: If Nam 27 is any injury or other tra once.		1 Burial 2 □ Cri	emation 3 🗆			rdens					b 19					
=	riand in Property	-	4 Donation 5			.						000	R	osed	dale		
Ba	Departr Importu any inje		21. Signature of Funeral	Service Liceni	2/	0	1 60	neme a	llv	ess of Facilit	ral	Home	of 1	Dund	alk	. p	Δ
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		2 1	23a. Part1. Enter the dis shock, or heart fail	seniur or comp	lications that	caused the dee	oth Do not ent	er the mo	de of dy	ing, such as	cardiac or	respiretory e	rrest,			Approxime Interval Be	ite
	Physician			9		1										Onset and	Deeth
	/Medical		Immediate Cause (Final disease or condition		VVI	2 ann	na									440	are
	Examiner		resulting in death)		a	10	or as a consec	uence of):							1	
	70 #	9															
	ordicate be assouted ing physician and a as the burlat-transit	edical Examiner	Sequentially list condition	ns,	b	Due to (or es a consec	uence of)):						1		
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n	The law requires that the death or the has been signed by the attend page 2 should be detached for us	Physician/	Part II. Other significant	conditions co	ntributing to 0	leath but not re	sulting In the u	nderlying	cause g	iven in Part I.		23b. Did	tobacco	use con	tributa to	the cause	of death?
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o o	ician: The certificata rector, pag	Ö	25. Was case referred to	madical						OC Disease	-4 D 1b		-	- Preo		1 100 20	Kino
5	Physician: this certific	o Be	axaminer?	-	Hospitel:	Itanatians of	75000		04 0	ther:		(Check only		0 004 -			
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5	Afte fun	호	1 Watural 5	Pending investigation	(Moi	nth, Day Year)	Injury	м	28c. Inju Wo	ork?]Yes 2∐l							
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Division of Vital	Director of Party of	=	4 Homicide	determined	build	ling, etc. (Spec	ify)	oot, racto	y, omoc			City or To					
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	Fun Fun	edical			iner: On the b	pasis of examination of steted.											(s)
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	4 7		Muhal	We	ul				- /	4149	_		2	-16	- 20	000	
1	MU		30. Name and address of	person who c	ompleted cau	se of death (Ite	m 23a) (Type,	Print)	4	# >		Bal-	la i	nd	21	23-	7
1	10 1		7105	nan	elin	Squ	are	UN	ye	, 0	13	1301	10. /	7 - 01	1		/
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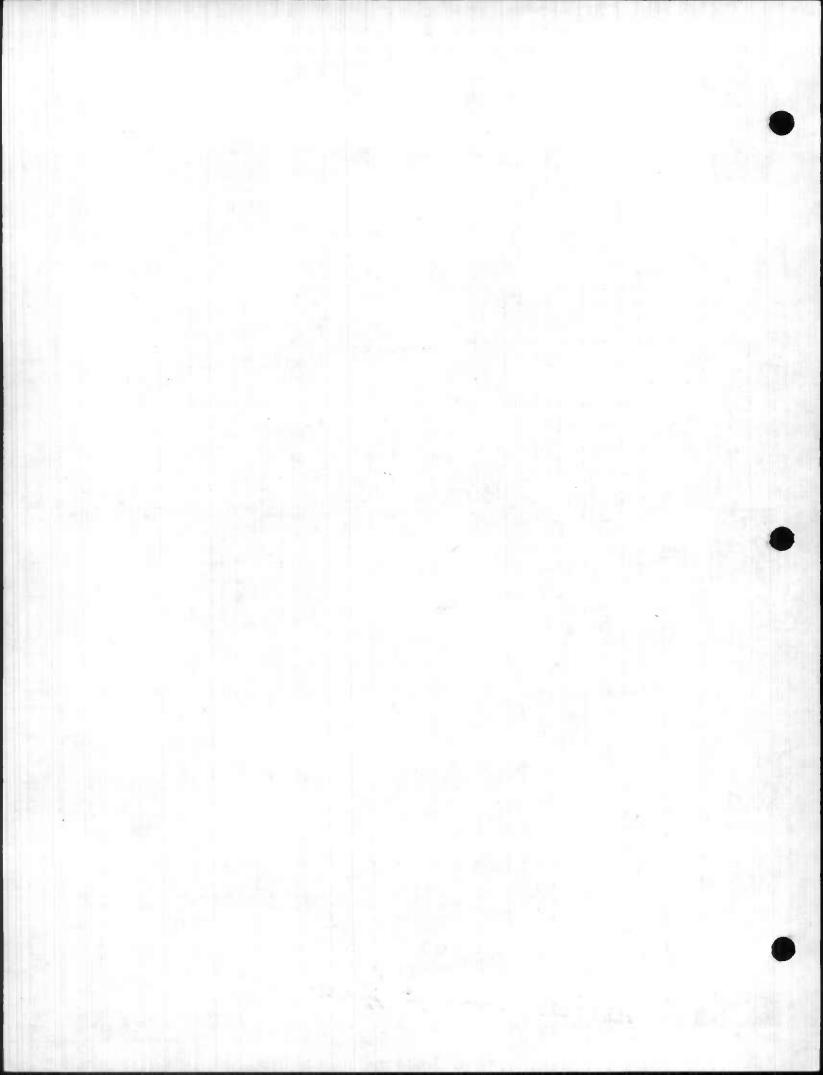
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Is Facility Nama (If not institution, give VA Maryland H 5. Social Security Number 6. S 577-30-5228 1 Usual Rasidence of Decedent 10a. Stata 10b. County WV Berkel 10c. Street and Number 602 Central Aver 11. Merital Status	e street and number) [ealth Ca: ex	(In yrs. last bit 76	Yrs. If Und Month		BALTIM	Janua: or Location of Deat ORE Hrs. 8. Date of Bin	cy 26, 4c. County N/A	2000 of Death	
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10a. State	IXM 2□F	76 10c. City, Tow	Yrs. Month			Ain. (Month, De	th Vanct	0 Birthole	on /Cinto or E
WV Berkel 10e. Street and Number 602 Central Aver						Sept.	1923	Wash	. D.C.
WV Berkel 100. Street and Number 602 Central Aver			AD OUT OCRITION	-				100	d. Insida City
10e. Street and Number 602 Central Aver 11. Merital Status		MOTE							1 Yas 2
602 Central Aver		narc	insburg	Zip Code			10g. Citizen of	Affect County	
11. Merital Status			101. 2		5401		USA	WHAT COUNT	y .
The second secon	12. Was Decedent E	ver in U.S.	13. Was Dec			(Specify Yes or No		e - Amarica	n Indian.
1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 [XYes 2 ☐ No If Yes, Give Year or Dates:			ecity Cul		? (Specify Yes or No uerto Rican, atc.)	Bla Specif	ck, Whita, at y: Bla	
		16a	Decedent's Us	wal Occu	ipation	working	16b. Kind of B	usinass/Indu	stry
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		Balt.	Wash.	Crem	atory	2/2/00	Laurel	Mar	yland
21. Signature of Funantial Service Little	Sho								
Wer De teles			7601	Sand	eral Hor	ne, Inc.	[aura]	MD 2	0707
3a. Part 1. Philef the disease, or comp	olications that caused t	he death. Do						1 1	Approximata Intarval Batwe
	b								
Sequentially list conditions, if any, leeding to immediata cause. Enlar Underlying Cause (Disease or injury that initiated events.	c								
	d	ue to (or as e	consequence or	ı):					
Cont II. Other slenitteest conditions or	and the state of a state because		- 44		turn in Daniel	025 014	1-h		
Part II. Other significant conditions of	ontributing to death but	not resulting i	n the underlying) cause 9	iven in Part I.				
								com	e autopsy find lable prior to spletion of causeth?
						10	Yas 2 No	10	Yas 2X N
25. Was case referred to medical					26 Place of				
axaminar?	Hospital: 1 Ki Innation	t 2∏ FR/0•	utpatient 3 1	DOA O	thac			ner (Specify)	
27. Mennar of Death			Time of						- 100
		rear)	Injury M						
	28e. Place of Injur building, etc.	y - At homa, fa (Specify)	arm, atreet, facto	ory, office				ber or Rural	Route Numbe
	iner: On the basis of e	examination an							
29b. Signatura end title of certifier			2	9c. Licen	se number		29d. Date signe	ed (Month, D	ay, Year)
Calata 14	211.25	KAN	1	240	1		andial	m 71	1 71
O Name and address of parent who	completed cause of the	ath (Itam 22e)) nuco	7-6	120
				ceen	e St	Raltim	re MI) 21	2.01
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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB. **Physician** 2000 15 KATHERINE DAVIS FRUMAN 6:40AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTIMORE-GILCHRIST CENTER TOWSON BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 F 76 219-60-9909 Director Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N Yes 2 No Director MD N/A BALTIMORE 28a-f 10a. Street and Number 10f Zio Code 10g. Citizen of What Country? 25 6124 STUART AVE. 21209 USA 238 Funeral 11 Marital Status Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 20 Merried 1 ☐ Yes 2X No If Yes, Give 21215-0020 8 1 ☐ Yes 2 No Specify: SpeciWHITE À 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER LUMBER altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental HARRY MILLMAN **JENNY** SHULMAN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Relationship (Type, Print) . nt of Health a if Item 27 is r or other tra 6124 STUART AVE. BALTIMORE, MD. 21209 LEONARD FRUMAN/HUSBAND 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Note: The state of the state o BETH EL MEMORIAL PARK 2/16/2000 RANDALLSTOWN, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CANCEY 13 months disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Due to (or as a consequence of) USB 85 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part II. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should be det Records, F à 24b. Were sutopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? **page 2** certificate 2 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: funeral director. Be 25. Was case reterred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 1 (WNatural 5 Pending Investigation death. 1 Tes 2 No 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide ò Hospital 24 hours a 150 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto Md 21204 6701 31. Date filed (Month, Day, Year) 2000 FEB 1 7 2000 32. Registraris Officeture FEB1 Registrar

DHMH 16 Rev 6/95

RUMAN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month 7.30 PM MARSHA -oster February 8,2000 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c County of Death hesA Anna polis 1448 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, peake nne HRundel 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) New YORK 6. Sex 10 M 20 F 058-32-7388 Yrs Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. insida Çity Limits Annapolis Anne Arundel 1 Yas 2 □ No MARYLand 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HESA 144 peake 14. Race - American Indian, Biack, White, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) . Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 202 No Whi 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry College (1-4or 5+) Elementary/Secondery (0-12) CounseLor 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Sta 20b. Place of Disposition (Nama of comatary, crematory or other place) 21403 aul 20a. Mathed of Disposition 20c. Location - City or Town, Stata 1 Buriai 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses Plouse ox ICKS

Physician /Medical

Examiner

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Physician

/Medical

Examiner

10a. Stata

Director

Funeral

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Completed

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Hem 27 is merked other than "natural", or flems 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours efter Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "netural", or ite

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

with the Maryland

Examiner ettending physician and for use as the bunel-transit

Physician/Medical by Completed Be 2 Certification:

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certificate has

f or Attending Physicien: 'effer death.
Director: After this certifica

To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th

23a. Part1. Entar tha diseasa, or com shock, or haart failure. List only	plications that caused tha death. Do not enter the mode of dying ona causa on each line.	, such as cardiac or rasplratory arrest,	Approximata Interval Between Onset and Death
Immediete Causa (Final disaesa or condition rasulting In daath)	· Breast d	ncek	FRES
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Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying	b		
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		24a. Was an autopsy performed?	24b. Ware sutopsy findings available prior to completion of cause of daath?
25. Wes casa rafarred to medical		1 □ Yas 2 No	1 ☐ Yes 2 ☐ No
axaminar?	Hospital: Otha	28. Placa of Death (Check only ona)	
27. Mennar of Death 1 Natural 5 Panding 2 Accidant invastigation	28a. Data of injury (Month, Day Year) 28b. Tima of lnjury Work' M 1 1 Y	at 28d. Dascribe how injury occur	nar (Specify) rred
3 ☐ Suicide 6 ☐ Could not be detarmined	28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)	28f. Location (Street and Numb City or Town, Stata)	ber or Rural Route Number,
29a. Certifiar (Check only one) Certifying Ph	ysician: To the best of my knowledge, death occurred at the time ilner: On the basis of examination and/or invastigation, in my ople and manner stated.	i, data and place, and dua to tha causa(s) and m Inlon, daath occurred at tha tima, data and place,	annar as stated. and dua to the causa(s)

State Registrar

Medical

29b. Signatura and titla of certifian

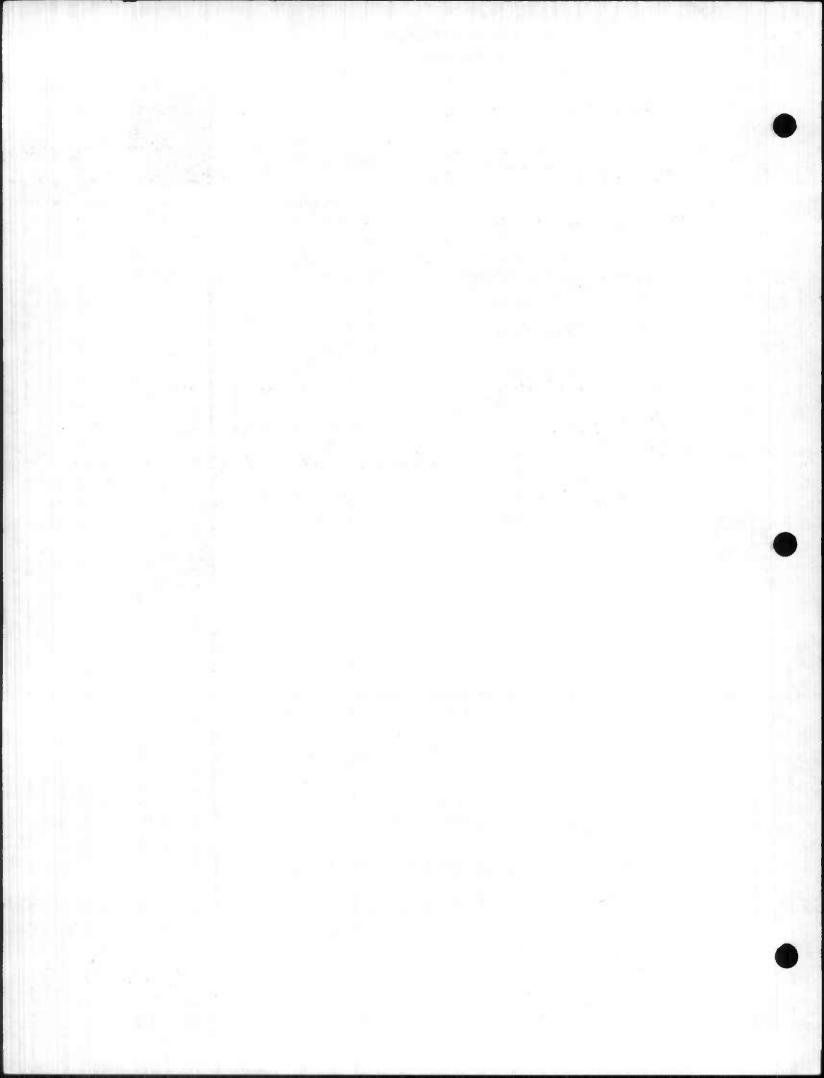
31. Data filed (Month

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

Selouich

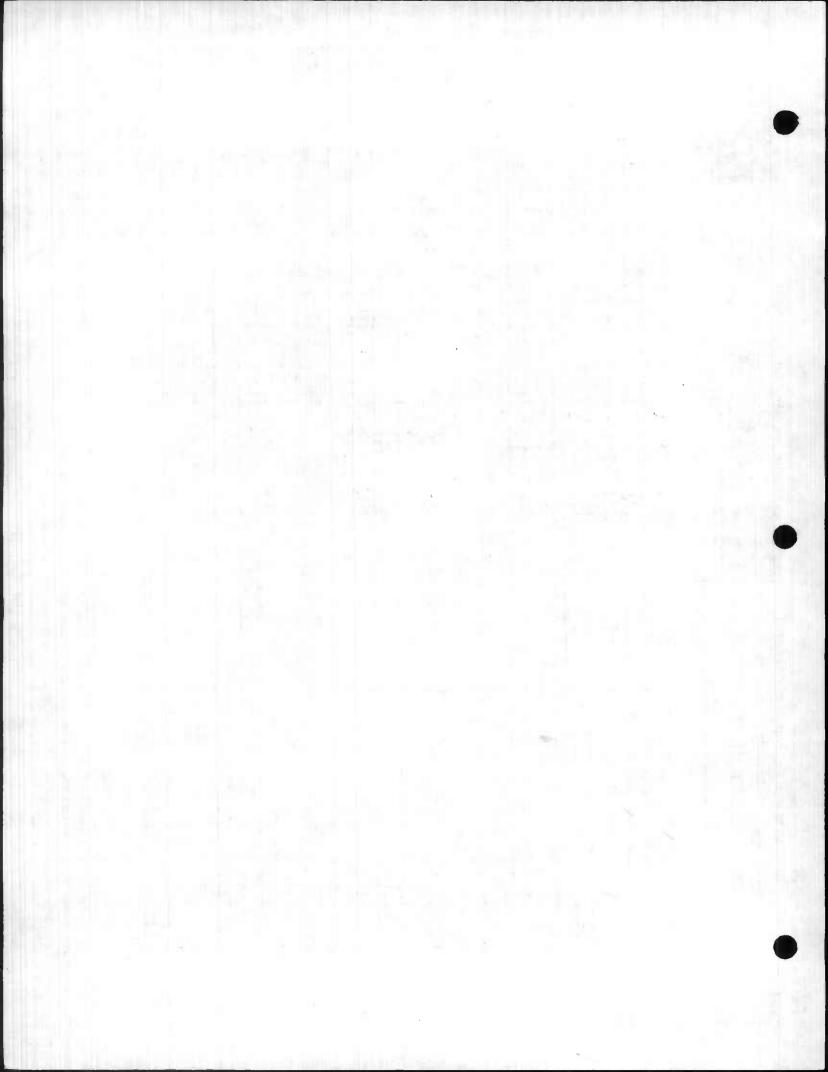
32. Registrar's Signatura

DHMH 16 Rev 6/95



				Certificat	e or	Death			Reg. No.		
Physician	Decedent's Name (First, Middle, PAULINE M.	(Last) GLANZER		20				2. Date of Do Month 02	eath Dev	Year 000	3. Time of Death 6:00 AM
/Medical Examiner	4e Facility Name (If not institution, 719 MAIDEN CHO)	give street and number;	APT. HR5	38				ocation of Dea	th 4c. County		
Funeral Director	5. Social Security Number 213-03-9398	6. Sex 7. Ag	ge (In yrs. last bir	thday) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 08-18-	rth ay, Year) -1918	Cour	place (State or Foreign ntry) YLAND
how how	Usual Residence of Decedent 10a. State 10b. County MD BALT	IMORE	10c. City, Town	or Location NSVILLE				100 10			0d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the Ma a or 28a-f a be notified Director	10e. Street and Number 719 MAIDEN CHO	TCE LANE.	APT. HR5	101. Zip	Code	212	228		10g. Citizen of U . S		ntry?
vours after death w urst, or hems 23s al Examiner must b d by Funeral I	11. Merital Status 1 □ Never Merried 2 □ Merrie 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces	Ever in U,S.	13. Was Dece	cify Cubi	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)		ck, White,	ean Indien, etc.
n 72 hou natura adical E	15. Decedent's (Specify only highest	Education	16a.	Decedent's Usu (Give kind of wo life. DO NOT u	al Occup	pation during mos	st of work	ing	16b. Kind of B	usiness/In	dustry
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fo Be	17. Father's Name (First, Middle, L RICHARD GRATZ	ast)						e (First, Middle BREMSTE	e, Maiden Sumar LLER	n <i>e)</i>	
sith and i	19a. Informant's Neme/Reletionshi JANICE M. ANDE								TT CITY,		21043
nent of He mt: If Ibem rry or othe	20a. Method of Disposition 1 ☐ Burial 2 □ Cremetion 3 4 □ Donation 5 □ Other (Spe		cemeter	Disposition (Na. y, crematory or o	ther pla	ce)	(Dete 02-17 2000	20c. Location BALTIN		own, Steta MARYLAND
Departr Importa any inju	21. Signature of Furieral Service Li	Consee A	1	22. Name ar HUBBAR				ME, INC			NS AVENUE MD 21229
nysician Medical xaminer	23a Fart1. Enter the disease or c shock, or heart feiture. List of Immediate Cause (Final disease or condition resulting in death)	a. Con	aestiv	1						\$ 1 \$ 1 \$	Intervel Between Onset and Death Weeks
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cartificate haractor, page	25. Wes case referred to medical	1				26 Plac	e of Deet	1 Check only	Yes 20 No	11	Yes 20 No
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2 2 2 5	27. Manner of Death Natural 5 Pending Accident investiga Suicide 6 Could no	ot be and Disco of to		М		ryat rk? Yes 2∐	l No		Street and Num		al Route Number,
	4 ☐ Homicide determin	building, el	ury - At home, fa c. (Specify)					City or To	own, State)		
n 24 hou se Fune pletsly fil edical	29a. Certifier Check only 2 Medical Ex	Physician: To the best xaminer: On the basis of and manner at	f examination an	, deeth occurred Vor investigation	at the tir , in my c	me, date ar opinion, dec	nd place, eth occur	end due to the red et the time	e cause(s) and m e, dete and place,	anner as s and due t	o the cause(s)
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	BULK	ronnung	7		DIE	070-	T		FEB /	0,	1000
0	30. Name and eddress of person w			Type, Print) TON AVEN				RE, MD	21229		100

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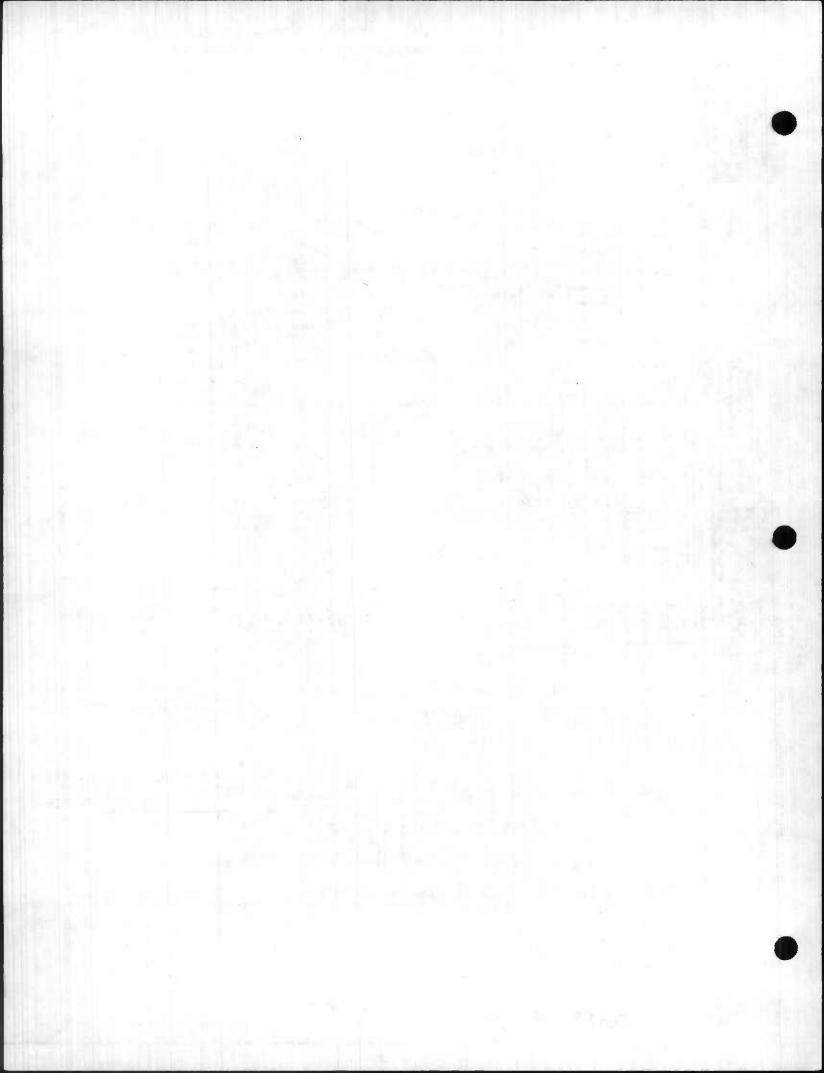


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: 326 PER MD G780 2-17-2000 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. 6, 2000 **Physician** William 0. Gayhardt 6:00 AM /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4409 Hooper Avenue Baltimore N/A 8. Dete of Birth (Month, Day, Year) MAR. 22, 19 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 11 M 2 □ F 214-40-1325 1942 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r 28a-f shound MD Anne Arundel Pasadena 1 Yes 2 XNo Funeral Director 10a Street and Number 10f. Zin Code 10g. Citizen of What Country? mast be 30 Milburn Circle 21122 USA death Rema 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hybjace.

Int: If Hean 27 is marked other than "natural", or he ury or other traumatic event, the Mental Hean interior 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Transportation Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Arthur Gayhardt Ethel Breitenbach 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Leslie Schurman - daughter 30 Milburn Circle, Pasadena, Md. 21122 20b. Place of Disposition (Name of cametery, crametory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 2/11/00 1XX Buriel 2 Cremetion 3 Removel from Stete Department of Important: If any injury or Meadowridge Memorial Pk. Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signeture of Funeral Service Licensee elon2 7250 Washington Blvd., Elkridge, Md. 21075 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Box 68760 certificate be Physician/Medical The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) DAUGHIERS HOME 2 X No Other: 4 Nursing Home Residence 6) Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient 2 28a. Dete of Injury (Month, Dey Year) 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? Affar Attending 1 Netural 5 Pending Investigetion 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 8 To the Funeral C Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

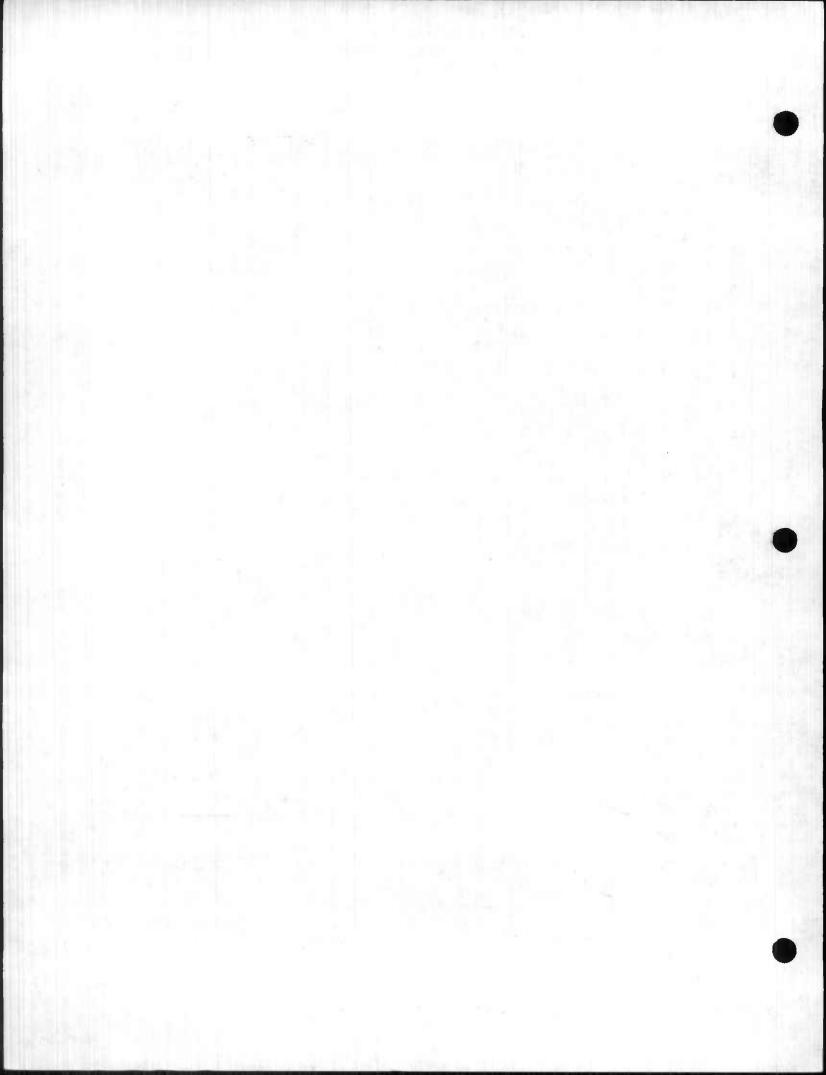
Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie densi 29b. Signatu (Month, Day, Year) cause of death (Item 23a) (Type, Print) Nam 2 South Greene to. 32. Registrer's Signeture State Registrar DHMH 16 Ray 6/95

ORIGINAL



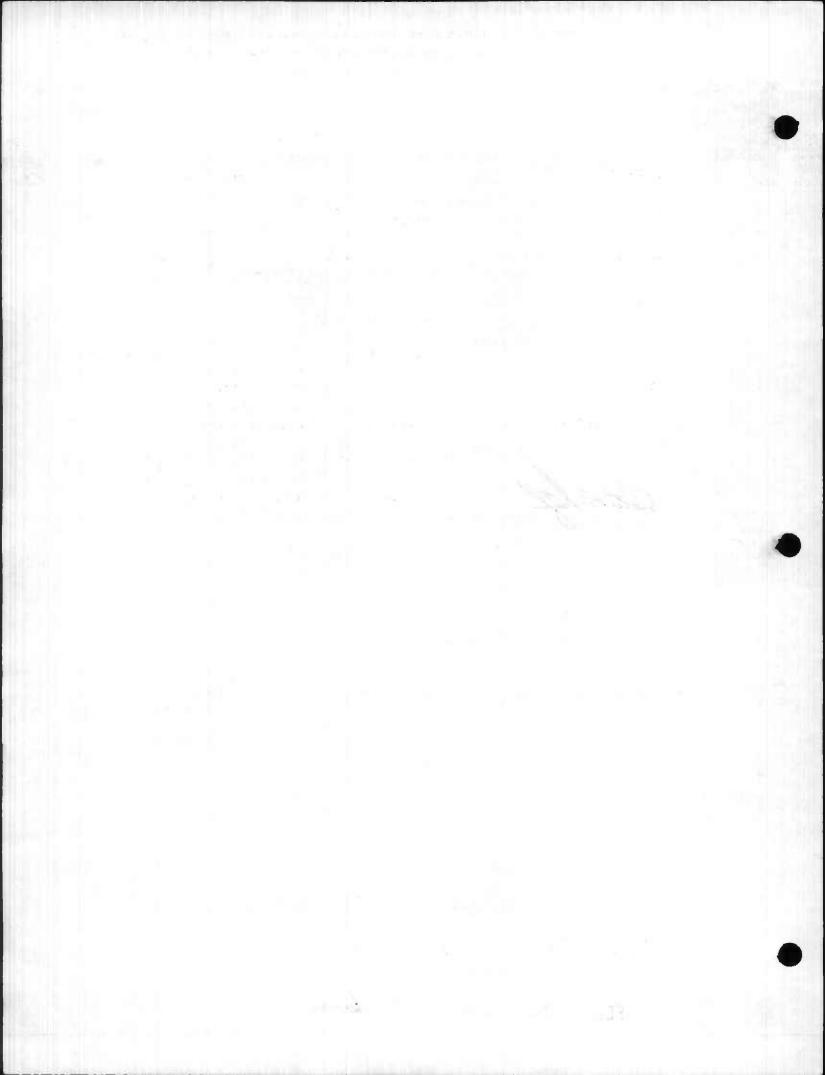
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 1, 9 0 3 State of Maryland / Department of Health and Mental Hygiene

	Certificate of	f Death F	leg. No.									
ualaian	1. Decedenl'a Name (First, Middle, Last)	2. Date of Dea Month	th Day Year 3. Time of Dea									
ysician Medical	DORIS Z. GOLDSTY		Y 13, 2000 9:55 PM									
aminer	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death									
- 4	MILFORD MANOR NURSING HOME	BALTIMORE	BALTIMORE									
al or	5. Social Security Number 214-22-0192 6. Sex 1 D M 2 M F 7. Age (In yrs. lest birthdey) Months Day		(, Year) Country)									
	Usual Residence of Decedent											
	10a. State 10b. County 10c. City, Town or Location		10d. Inside City L									
cto	MD BALTIMORE BALTIMORE		1 □ Yas 2√									
al Director	10e. Street and Number 4204 OLD MILFORD MILL ROAD	21208	10g. Citizen of What Country? U.S.A.									
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of If Yes, specify Ct. 14. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	f Hispanic Origin? (Specify Yes or No- uben, Mexican, Puerto Rican, etc.) o Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE									
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E	Z College (1-407 5+) TEACHER		EDUCATION									
BeC	17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle,	Meiden Surneme)									
To B	JACOB ZUBIN	HANNAH	BRODIE									
-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	et and Number or Rural Route Numbe	r, City or Town, State, Zip Code)									
		EWA COURT - BALTIN										
	20s. Method of Disposition 20b. Place of Disposition (Neme of	Date	20c. Location - City or Town, State									
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200	4 Donation 5 Other (Specify) BETH TFILOH CEME		WOODLAWN, MD									
9000	21. Signature of Funeral Service Lipsensee 22. Name and Add 8900 REIS	, SOF PEATI	SON & BROS., INC. PIKESVILLE, MD 2120									
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line.											
n	shock, or heart failure. List only one cause on each line.		Interval Between Onsel and Dea									
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8		24a. Was	an autopsy med? 24b. Were autopsy tind available prior to									
Completed		perio	completion of cau									
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Be	25. Was case referred to market examiner? Hospitel: Hospitel:	26. Piece of Deeth (Check only o										
7	1 Inpatient 2 ER/Outpatient 3 DOA	4 Nursing Home 5 Hesio	dence 6 Other (Specify) now injury occurred									
O	27. Manne of Death 1 Natural 5 Pending 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury W		on injury occurred									
Certification:	2 Accident	Yes 2 No	News and Manhara Co. 10. 11. 11.									
E	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	281. Location (3 City or Tow	Street end Number or Rural Route Numbe vn, Stete)									
Ce			THE PROPERTY.									
E C	29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and/or investigation, in my knowledge, death occurred at the course of examination and occurred at the course of examination a	time, date end plece, and due to the	cause(s) and manner as stated.									
edical	one) Nedical Examiner: On the basis of examination and/or investigation, in manner stated.	y opinion, deeth occurred at the time, (yare and prace, and due to the cause(s)									
Σ	29b. Signature end tillulal contiller 29c. Lice	ense number	29d. Date signed (Month, Dey, Year)									
5	Alland To Vasal Club	7.7034	February 14,20									
	20 Name and address of access the same of days (in the color of the co		100000									
	30, Name and address of person who combleted ceuse of death (Item 23a) (Type, Print)	1. LO 0 00-	alle wallen a.									
	Ira Honter Copeland Mb 5310 Ula	WIT LOAD KIN	Malistan Lin SII									
ate	31. Dele filed (Month, Dey, Year) 32. Registrar's Signature											



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Description					State of W	arylaric				Death	лентат пу	Reg. No.		
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Commerce		end lealth m 27			Daughter	Jan. 5.				Avenue B				
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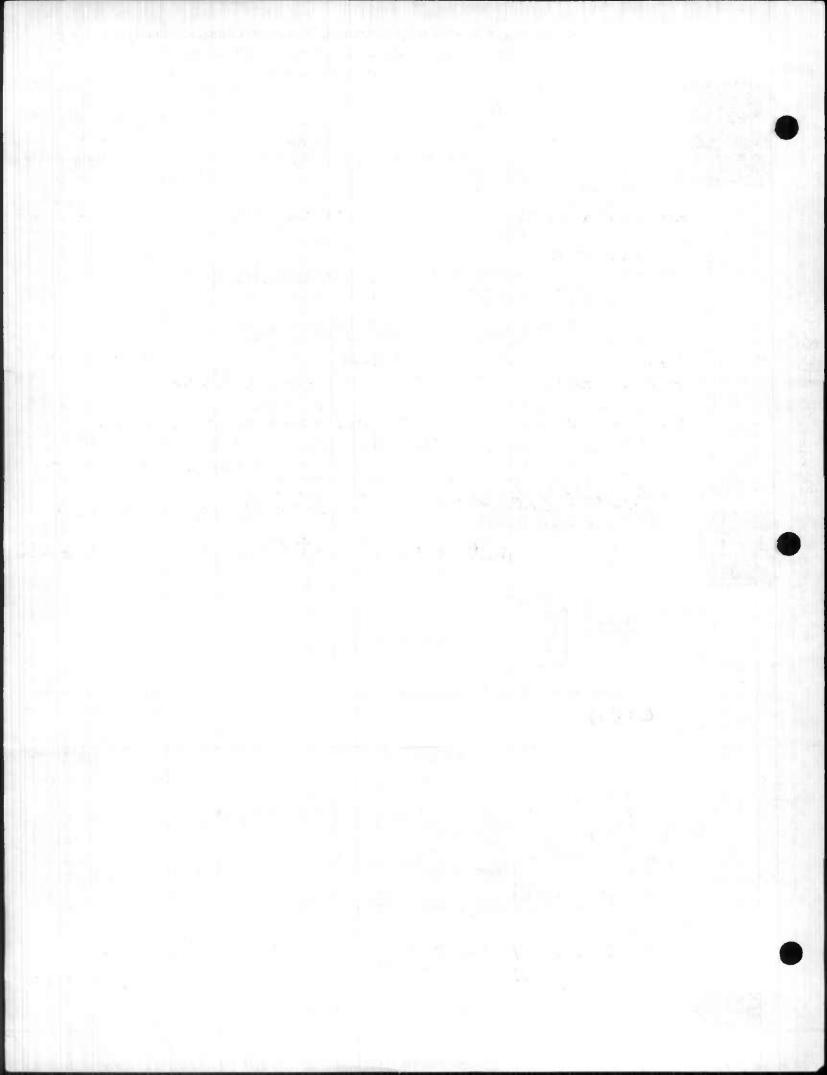
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					Certific	cate of	Death		Reg. No.		
Dhoraini	4.	1. Decedent's Neme (First, Middle, Last,) i i	16				2. Date of De		Year	3. Time of Death
Physici /Medi		Doris	Hor	all		155				207	8:10 PM
Examir		4a. Facility Name (If not institution, give					4b. City, Town, or L				
		4218 Hamilton Aven	ue				Baltimore	-		imore	
Funeral Director		5. Social Security Number 6. Sec. 199 24 9542	7. Ag	e (In yrs. last		Inder 1 Year oths Days		8. Date of Birt (Month, Da May 24	y, Year) ,1932	9. Birthpla Country York	ce (State or Foreign
land		10a. State 10b. County		10c. City, To	own or Location	1				100	d. Inside City Limits
ith the Marylar or 28a-f show	io to	MarylandBaltimore	City			Ba	altimore C	ity			XX Yes 2 No
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h with	D IS	4218 Hamilton Avenue			2	1206			USA		
Maryiand ZIZID-UUZU d 2 should be filed within 72 hours aftar death with the Maryland th and Mental Hygiane. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified as	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give N Year or Dates:			ecadent of specify Cul	Hispanic Orlgin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Rac Blac Specify		c.
72 hours "natural",	P	15. Decedent's Edu	cation		Sa. Decedent's	Usuel Occu	pation		16b. Kind of B	Whit usiness/Indu	
Med A	Completed	(Specify only highest grade Elementery/Secondary (0-12)	e com <i>pleted)</i> College (1-4or 5		(Give kind o	of work done OT use retir	a during most of work	ting			
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Ment Ment arked	ဥ	Edward A. Dressell					Evelyn N	v. Yingi	ing		
d 2 should be filed than Mental Hyg		19e. Informent's Name/Relationship (Ty		1	-		et and Number or Run				
CENL		Mr. Terry N. Leipo	oTq	0.01			on Avenue				
Pages 1 nant of H nt: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	temoval from State	20b. Place ceme	of Disposition tery, crematory	(Name of or other pla	aca)	Date	20c. Location -	City or Town	n, State
permit. Pages 1 and Department of Haalth Important: If Item 27 any Injury or other tronce.		4 □ Donation 5 □ Other (Specify)		Most	Holy R	edeem	er_Cem2	2-14-200	00_Balti	more,	Md. 21236
permit. Pages 1 ar Department of Haa Importent: If Item 2 any Injury or other pnce.		21. Signature of Funeral Servica License	96	1						,	
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/Medicai Examiner		Immediate Ceuse (Finel disease or condition resulting in death)	net	asta	tic 1	Mea	est Ca	renon	na		10 march
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ficata be axecu physician and is the burial-tra	Xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or as	a consequence	a of):					
icata be axecuted physician and s the burial-transit		Cause. Enter Underlying Cause (Disease or Injury that initiated events)								
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uttendin daath. ctor: Af y tha fu	atic	2 Accident Investigation			М]Yes 2□No				
	Certification:	3 Sulcide 6 Could not be determined	28e. Place of Injubuliding, etc.	ury · At home, c. (Specify)	farm, street, fa	ctory, office		28f. Location (S City or Tox	Street and Numb vn, State)	per or Rural F	Route Number,
To the Hospital or within 24 hours after To the Funeral Director Completely filled in	edicai	29a. Certifier 12 Certifying Physical Control (Check only one)	lictan: To the best of ter: On the basis of and manner sta	examination	lge, death occu and/or investig	rred at the t ation, in my	ime, dete end plece, oplnion, death occur	end due to the red at the time,	cause(s) and made and place,	anner as stat and due to ti	led. he cause(a)
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)_		n	Hali	m	n		020396		Fel-	1 2/1	21)
0		30. Name and eddress of person who co	mpleted cause of de	eath (item 23	a) (Type Print)		4	. 0		, , ,	1
1		Dauis A	Hahn	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		10	Baren B	Bul ,	Ba Ho	mo	21239
Sta	te	31. Dete tiled (Month, Dey, Year)	32. Registre	er Signature	-	1	mel			,	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 1, 9 0 6 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Yee 4457 AM FEBUARY 14, 3000 4c. County of Death 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Baltimore City If Under 24 Hrs. 8. Date of Birth Eldercare Caton manon GENESIS If Under 1 Year 8. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Min 10 M 201 Hours Months 219-14-0648 Usual Residence of Decedent 10a State 10b County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 No timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 400 mi MHON 12. Wes Decedent Ever In U.S. Armed Forces? 1 Yes 2 2 No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) - American Indian Black White etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced lack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) ?arrie Jam es Harri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIN 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other place) 1 DBurial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) polis MeMoria 22. Name end Address of Fecility 21. Signature Funeral Service Licensee/ HICKS 1922 Forest disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or failure. List only one cause on each line. Approximete Interval Between Onset and Death Day immediate Cause (Final disease or condition resulting in death) RAD Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of) Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 20 No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

Division of Vital Records, P.O. Box 68760,

attending physician and for use as the burial-transit Physician/Medical 8 been signed by the a should be detached Completed page 2 Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

vith and Mental h

of Health a

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Funeral Director

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Completed

Be

with the Maryland

Grris, Edna

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I

State

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

C-V-C4RIAC-M-D \$109 R17C41B

Medical

31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

2 Accident 3 Suicide

4 D Homicide

29a. Certifier

32. Registrar's Signature

Attending Docter

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RITCHIB HONY

29c. License number D21684

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated.

29d. Dete signed (Month, Day, Year)

2-15-2000

281. Location (Street and Number or Rural Route Number, City or Town, State)

FEB 1 7 2000 Registrar

investigation

6 Could not be determined

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Home maker

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00-0684-510 B.K.S amend	per me G780 2/17/0 item 23a,27, Please T	ype or Print in t	Black Inc	delible ink	c. Assul	re All Copie	s Are Legi	ble.L	907
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Physician /Medical	CHARLES HARRIS					Month FEB	. 6, 200	Year ()(2:32 PM
Examiner	4a Facility Name (II not institution, give s BON SECOUR HOSE	etreet and number) PITAL E.R.			BAL	m, or Location of De FIMORE	eath 4c. County	of Death	
Funeral Director	5. Social Security Number 6. Sex 213-86-7741	7. Age (In yrs. 37	last birthday) Yrs.	Months Days		Min. 8. Dete of (Month, 1-16			aca (State or Foreign ny) lland
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with the Ma t or 28e4 s be notified Director	10e. Street and Number			10f. Zip Code		-	10g. Citizen of 1	What Countr	ry?
ath will be seen and will be seen to see the s	3409 Walbash Ave.			21217			USA.		
020 urs atter death v st., or heres 234 Examiner mast by Funeral	11. Marital Stetus 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 		Ves Decedent of Yes, specify Cub ☐ Yes 2√ No		in? (Specify Yes or Puerto Rican, etc.)	No- 14. Rad Bia	ce - American ck, White, et	tc.
hursi al Ex	15. Decedent's Educ	Yeer or Detes:	16a Deced	ent's Usual Occu	nation		16b. Kind of B	Black	
Maryland 21215-0020 d 2 should be filed within 72 hours after and Mental Hybjano. 77 is merked other than "natural", or its resumetic event, the Medical Examine To Be Completed by Fu	(Specify only highest grade Elementary/Secondary (0-12)		(Give I	kind of work done OO NOT use retire	during most	of working		awrant	
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, Marylan and 2 should be saith and Mental n37 is marked o ser traumatic eve	Clifton Henry				0 de	ssa Whitt	ington		
Maryla 2 should 12 should 18 merke reumeric	19a. Informant's Name/Relationship (Ty)		-	- Indiana Company		or Rural Route Nur			
Health Health Health Health Health	Odessa Whittington 200. Method of Disposition			vacoas n	Ave. B	altimore	20c. Location		
Mor ages	1 Burial 2 Cremation 3 Re	emoval from State	emetery, crem	atory or other pla		2-12-00			
Saltimore, emit. Pages 1 ar separanent of tes moortent: if them 3 my injury or other mos.	21. Signature of Funerel Service License			Mem Par					Home P.A.
w sales	1 You 01,	Ptel				e Baltimo			
Physician /Medical Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final diseasa or condition resulting in death)	NARCOTIC AN	h. Do not ente	er the mode of dy	ing, such as o	eardiac or respirator			Approximate Interval Between Onset and Death
bouted transit		500 10 (0	as a conseq	derice orj.				1	
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to (o	r as e conseq	uence of):					
S87 icate phys s the	Cause (Disease or Injury that initiated events reaulting In death) Last	Due to (o	r es e consequ	uence of):					
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P.O. that the ded by the detached	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause g	iven in Part I.				the cause of death? ably 4 Unknown
0 4 40						24a. W	las an autopsy enformed?	avai	re autopsy findings ilable prior to appletion of cause eath?
The law ate has page 2						0	Yes 2 No	A	Ves 2□ No
Vital Incentificate irrector, pag	25. Was case referred to medical examiner?					of Death (Check on	ly one)		>
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After funer	1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ork?]Yes 2.↓∏.N		oe how injury occui	rea	
Division of standing P rs after death. at Director: After tied in by the funer Certification:	3 ☐ Suicide 6 ☐ Could not be	2/6/2000 28e. Place of Injury - At he	unknow ome, farm, stre		14	28f. Location		ber or Rural	Route Number,
Div.	4 Homicide	found on po	y) _			Baltin	rown, State) 20 nore, Md.	3 West	Route Number, twood Ave.,
Hospi 24 hou Funer Hospi Mical	29a. Certifier (Check only one) (Check only one) (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the t estigation, in my	ime, date and opinion, deat	place, and due to the control occurred at the time	he cause(a) and m	anner as ata	nted.
To the within 2 To the comple	29b. Signature and title of certifier	eith			c.M.E	YT.	29d. Date signe FEB.		2000
5	30. Nama and address of person who con				, Balt	imore, Ma	ryland 21	1201	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa							
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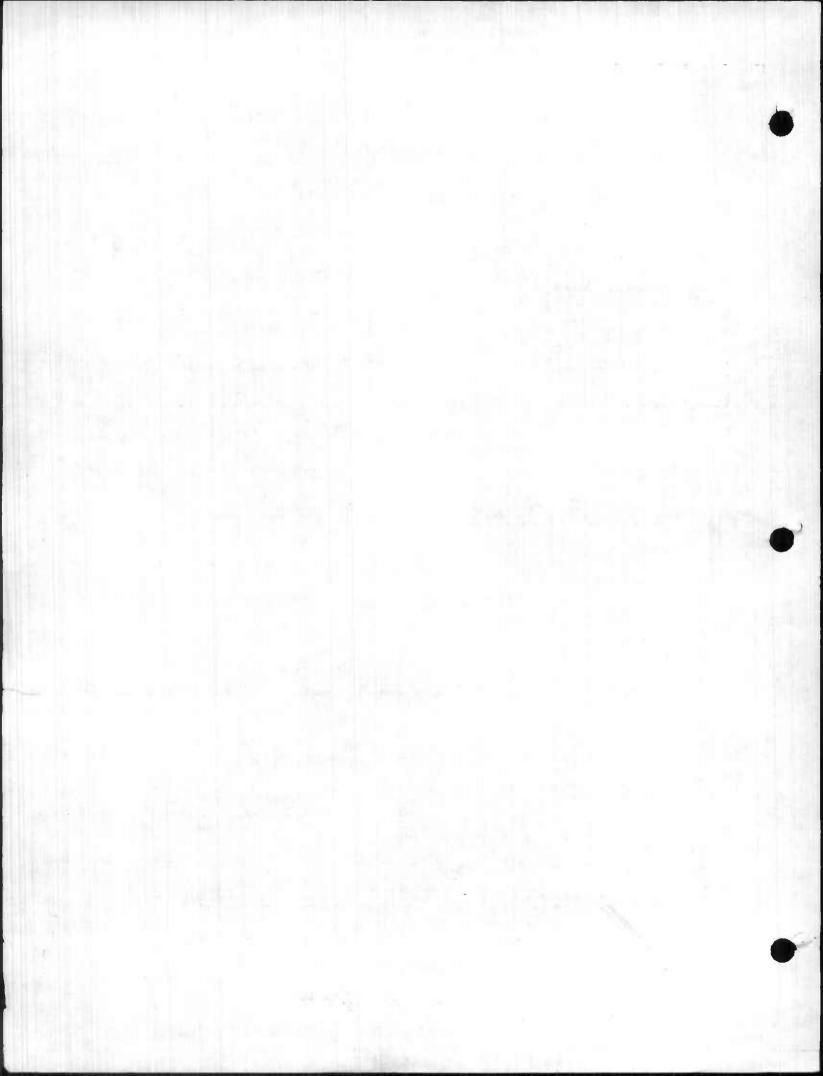
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AMEN	DED	TIEM #/ PER	FH G/80 2/1//2000 A	Н		Cei	rtificate o	t Death		Reg. N	io.		
			1. Decedent'a Name (First, Middl	e, Last)					2. Date of Month		ay	Year 3.	Time of Death
		Physician	HANNI EDWAND	HAINES							4, 2		:40 PM
		/Medical Examiner	4 55 201 44 444 11 12 12	n, giva street and nu	m <i>ber)</i>			4b. City, Tow	n, or Location of			y of Death	. 10 211
	1	Examiner	Stella Maris					Towson	,			imore	
			5. Social Security Number	6. Sex	7. Age (In yrs. last	t hietholou)	If Under 1 Yea						(State of Coming
	-	Funeral	218-12-4444	1₩ 2□F		85 Yrs.	Montha Day		Min. (Month	Birth h, Day, Year 2, 19	31	Country)	(State or Foreign MD
		Director	Usual Residence of Decedent	Λ	00				pec 2	2, 19	14		עמ
		2	10a. State 10b. County		10c. City, T	own or Lo	cation	-				10d A	nside City Limits
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		with the Maryland a or 28a-f show be notified at Director	10e. Street and Number				10f. Zip Code			10g. C		What Country?	
×		W. P. S.		enue #1	407			212	11		US.	A	
P.M		fler death v fler must instrument Funeral	11. Marital Status	12. Was Decr	edent Ever in U,S.	13. \	Was Decedent o	Hispanic Orig	in? (Specify Yes of Puerto Rican, ato	r No-		ce - Amarican In	idian,
0	0	after mine	1 ☐ Nevar Marriad 2 Marr	ried 1.4\(\square\) Yes	2 No _				ruello ricali, atc	.)	1	ck, White, atc.	
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	70	ed within 72 ho yglene. Are then "natura", the Medical.	(Specify only higha:	st grada completed)		(Giva	dent's Usuat Occ kind of work dor DO NOT use reti	ne during most ired)	of working				
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February	Baltimore,	五五百年	20a. Method of Disposition		com	e of Dispo	sition (Name of matory or other p	olace)	Date	20c.	Location -	- City or Town,	Stete
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e	=	of the state of			20 57 5	a 39	Name and Adr	trace of Facility					
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that o	ausad the douth. I	Do not ent	er the mode of d	lying, such as c	ardiac or respirat	ory arrest,	1	App	roximate rval Between
		Physician		, , , , , , , , , , , , , , , , , , ,								One	set and Death
		/Medical	tmmediate Cause (Final	Cer	ebrovascu	iler	Accident	-					
		Examiner	disease or condition resulting in death)	a. OCI				_				1	
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		icate be executed physician and is the burlat-transit edical Examiner		b								1	
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S		that the death or ted by the attend detached for us y Physiciany	Part II. Other significant condition	ons contributing to de	eath but not resultin	ng tn the ui	nderlying cause	given in Part I.	23b.	Did tobacc	co use co	ontribute to the	cause of death?
Haines	P.O.	by th								1 Yes	2 □ No	3 ☐ Probable	4X Unknow
21		signed to be det									20110		20 0
	Records,	8 99 0							248	Was an aut	tonsv	24b. Were a	utopsy findings
Harry	Ö	The law requir sate has been s page 2 should Completed								performed?	,	availab	le prior to tion of cause
ar	9	has the pe 2 s							- K-			of death	1?
H	H	The la								1 Yes	2 No	1 ☐ Ye	s 2 No
	0	certificate rector, pag	25. Was case referred to medical					26. Place	of Deeth (Check	only one)			
	of Vital	Physician: this certific ral director,		Hospital:	Inpatient 2 ER	/Outpatien	nt 3 DOA	Other: 4 Nur	sing Home 5	Residence	8 (30)	her (Specify) H	OSPICE
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	Division	rs after death. Tal Director: After the funeral of the funeral certification:	1 Netural 5 Pendin		th, Day Year)	Injury		Vork? ☐ Yes 2 ☐ N	lo				
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	<u>></u>	Mer Aired in 59 in 50 in	4 ☐ Homicide determ	ined buildi	of Injury - At home ng, etc. (Specify)	e, ratini, stri	eet, factory, offic	20	City	r Town, Sta	ite)	Der Or Hural Hor	no realition,
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		n 24 hound no 24 hound no Funer pletely fill edical	29a. Certifiar 1 Certifyin	g Physician: To the Examiner: On the be									
		Plet plet	one)		ner stated.		rostigation, arm	y opinion, door	TOCCOTTOG SE ETO	ino, date a	na piace,	and doe to the	cause(s)
-	-	To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the f Medical Certificati	29b. Signature and title of certifie				29c. Lies	nse number	- /-	29d. D)ata signo	ed (Month, Day,	Year)
			1/d/2/16.	12 20			1	155	04	2	4	00	
			20 Name and address of a	uho pometate de co	a of do at the same) (T.	Daint)			1	-		
			30. Name and address of person Dr. Eddie Na					ad. Tim	onium M	D 2	1093		
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DHMH 16 Rev 6/95

State Registrar



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State of Maryland / Department of Health and Mental H	lygien	E
27 PER MED C781Cortificate of Death		

JOSEP	H HOL	LOWAY				State of Maryland / D	enartment
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		1. Decedent's Name (First, Middle, Last)								2. Date of Death Month Day Very 3. Time of Death					
	Physician	JOSEPH HOLLOWAY							FEBRU	Month FEBRUARY 12 2000 7:3			Δ		
- 5	/Medica							4 0 T							
	Examine			um <i>ber)</i>				4b. City, Town, or	Location of De						
		404 KENILWOR		TOWSON				BAL.	LIMORI	LMORE					
3-	Funeral	5. Social Security Number	6. Sex	Sex 7. Age (In yrs. last birthday) 51 Yrs.		Months Days		If Under 24 Hr		Birth	9. Birthplace (State or Foreig Country) 1948 BALTIMORE, MD.				
L,	Director	214-50-1681	1₩ 2□ F					Hours Mir	. 1111 V	19,1948			MD		
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	2 .	10a. Stafe 10b. County 10c. City, Town or Location 10d. Inside Cit										'ity I imite			
	the other		****												
Baltimore, Maryland 21215-0020	2 18 5	MARYLAND	BALTI	TIMORE				, X.			2 No				
	or 28a-f	10e. Streel and Number			10f. Zip Code					10g. Citizen o	What Cou	ntry?			
			N ROAD		21207			7		USA					
	r here death v r here 23 diner mast	44 Medial Status	11. Marital Status 12. Was Decedent Evar in												
	0 10 1	11. Marital Status	Armed F	orces?	J. 13. H	Yes, speci	y Cub	lispanic Origin? (an, Mexican, Pue	nto Rican, etc.)	etc.) Black, White, etc.					
			ied 1 Yes	2 XNo Sive	1	1 ☐ Yes 2 ☒ No Specify:				Spec	Specify: AFRO AMERICA				
	Exer.	3 Widowed 4 Divorced	Year or	Year or Dales:							AFRU AMERICA				
	72 h	15. Decedent	15. Decedenl's Education				16a. Decedent's Usuel Occupation				16b. Kind of Businass/Industry				
	9 69 6	(Specify only highest grade completed)			16a. Decedent's Usuel Occupation (Give kind of work done during most of workin life. DO NOT use retired)				KKING						
	ed within 72 ho ygiene. wer then "naturn it, the Medical I	12	Elementary/Secondary (0-12) College (1-4or 5+)			HANDYMAN				ODD JOB					
	BEER C	17. Father's Neme (First, Middle,	17 Eather's Name (First Middle Leat)							(First, Middle, Maiden Sumame)					
	STORE S	5													
	Wend Wend	LEROY HOL	LOWAY S	R.	FANI				IE HOLLOWAY						
	d DE S	19a. Informant's Neme/Relations	hip (Type, Print)		19b. Meilin	g Address	(Street	and Number or F	lural Route Nun	nber, City or Tow	n, Stete, Zi	p Code)			
	2 de 1	BARRY MITCH	IELL		816	KEVIN	RO	AD RALT	IMORE	MADVI AN	D 212	29			
	-414	BARRY MITCHELL 816 KEVIN ROAD, BALTIMORE, MARYLAND 21229 20a. Method of Disposition (Name of Date 20c. Location - City or Town, State													
	0 m 0	1€ Burlal 2 □ Cremation 3 □ Removal from State cemetery, cremetory or other piece)													
	Part of	ARBUTUS MEMORIAL RARK 2/19/00 ARBUTUS, MARYLAND													
#	がなる。	21. Signatury of Funeral Service	Licensee	10	22	Name and	Addre	ss of Facility							
m	88188		110 4	16	> ES	LES B	ROS	ss of Facility FUNERA	L SER,	P. A.,					
_		VVX	10	9/	113	00 EN	TAW	PLACE,	BALTIMO	RE, MAR	YLAND	21217			
		23a, Part1, Enter the disease, or shock, or hear failure. List	domplications that only one cause on	each line	n. Do not ente	er the mode	of dyir	ng, such as cardi	c or respiretory	arrest,	- 1	Approxima Interval Be	reewh		
	Physician	The state of the s		INTRACEREBRAL HEMORRHAGE ASSO						MITH	1	Onset and	Death		
	/Medical	Immediala Causa (Final		HYPERTENSIVE ATHEROSCLEROTIC					CARDIC	VASCULA:	R				
	Examiner	disease or condition resulting in death)	8.	aDISEASE							-				
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68760,	certificate be exiding physician ise as the burla	resulting In death) Last		Due to (or as a consequence of):											
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	uires that the death signed by the etter ild be deteched for a	Part II. Other algnificant condition	na contributing to	death but not resu	ulting in the un	nderlying ca	use di	ven in Part I.	23b. D	id tobacco use d	ontribute	to the cause	of death		
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5	been sign should be								24a. W	es an autopsy rformed?	a	vailable prior	to		
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-	To I	1 N Yes 2□ No	Hospital: 1	Hospital: 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing						fome 5 ☐ Residence 6 ØOther (Specify) SCENE					
o	or this eral di		28e. Dale	of Injury onth, Day Year)	28b. Time of	28	Bc. tnjun Worl	y at	28d. Describ	scribe how injury occurred					
on	After the funeral form:	1 Natural 5 Pendin		nin, Day Year)	Injury	м		rk? Yes 2 □ No							

To the Hospital or Attendit within 24 hours after death To the Funeral Director: A completaly filled in by the fi

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and fitte of cartifiar 29c. License number 29d. Date signed (Month, Dey, Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 2004) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

281. Location (Street end Number or Rural Route Number, City or Town, State)

FEBRUARY 12,2000

State Registrar

Medicai Certifica

3 Suicide

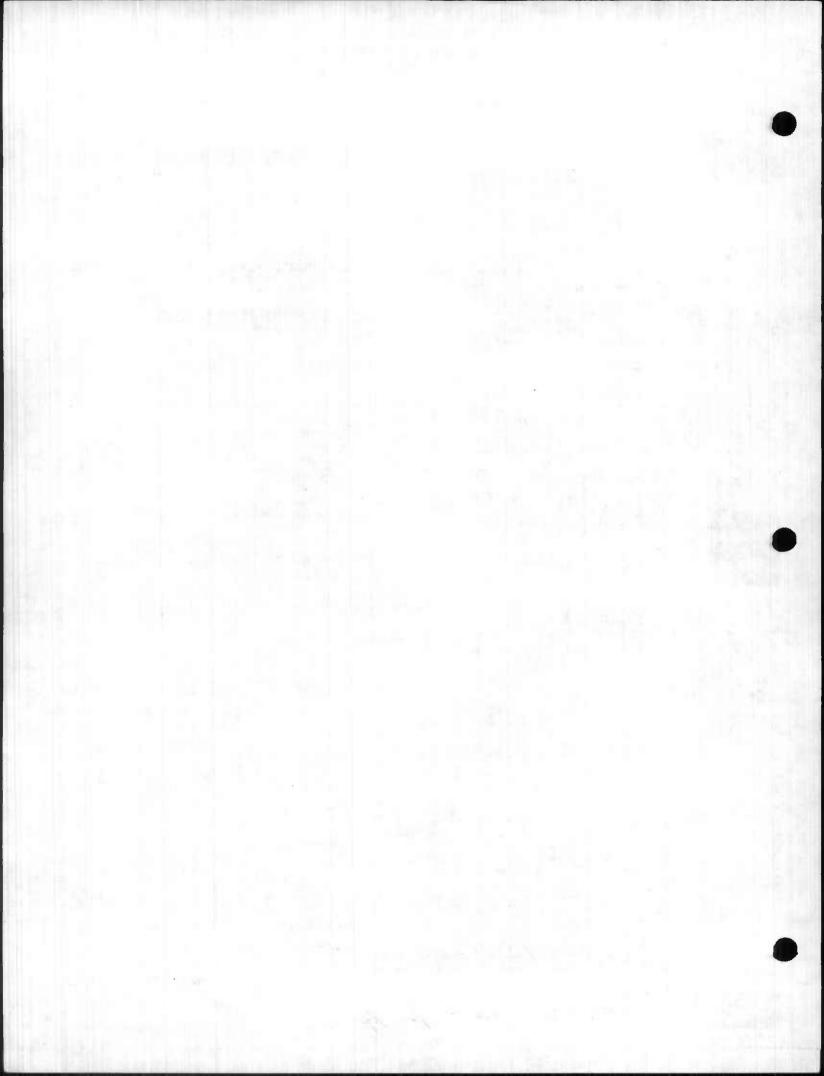
4 Homicide

Stephen S. R 31. Dale filled (Month, Dey, Year) FEB 1 7 2000

6 Could not be determined

adentz 32. Registrar's Signature

O.C.M.E



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year ELIZABETH HENDERSON February 14, 2000 7:20 P.M.

> 10d. Inside City Limits 1 No Yes 2 No

White

21212 Approximate Intervat Between Onset and Death

Physician HELEN /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Long Green Nursing Home Baltimore If Under 1 Year 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1□M 2\0 F Yrs 92 217-60-4117 Director West March 18, 1907 Usual Residence of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location Director Maryland N/A Baltimore 28a-f 10e Street and Number 10f Zio Code 10g. Citizen of What Country? mant be r 115 E. Melrose Avenue 21212 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? filed within 72 hours after 1 ☐ Yas 2 X No 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Yes, Give Specify: þ 3 ₩ Widowed 4 Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years Hygiene. College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill then of Health and Mental H tant: If less 27 is marked objury or other traumatic even Be Hildt Barnhardt Eugene Elizabeth Maneffe 19e. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Riggs (Executor) 555 Fairmount Avenue Towson, Maryland 21286 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 M Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Department Important: If any injury or once. 2-16-2000 Green Mount Crematory Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funerel Servica Licansee 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart feiture. List only one cause on aach lina. 6500 York Road Baltimore, Maryland **Physician** /Medical Immediate Cause (Final AccileNT CEREBROVASCULAR disease or condition resulting to death) Examiner Due to (or as a consequence of) Examiner HAS WD burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): LZ HEIMENS Box 68760. Physician/Medical the Due to (or as a consequence of) 8 for use P.O. signed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 24a. Was an autopsy performed? page 2 should has 1 Yes 2 NA certificate or Attending Physician: funeral director, Be 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) Certification: To 1 Yes 2 TONo 1 Inpetient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Naturat within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital completely

23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Meumber M D0007691 wen 000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 7505 GSLER DY 87301. TOWSON, MD

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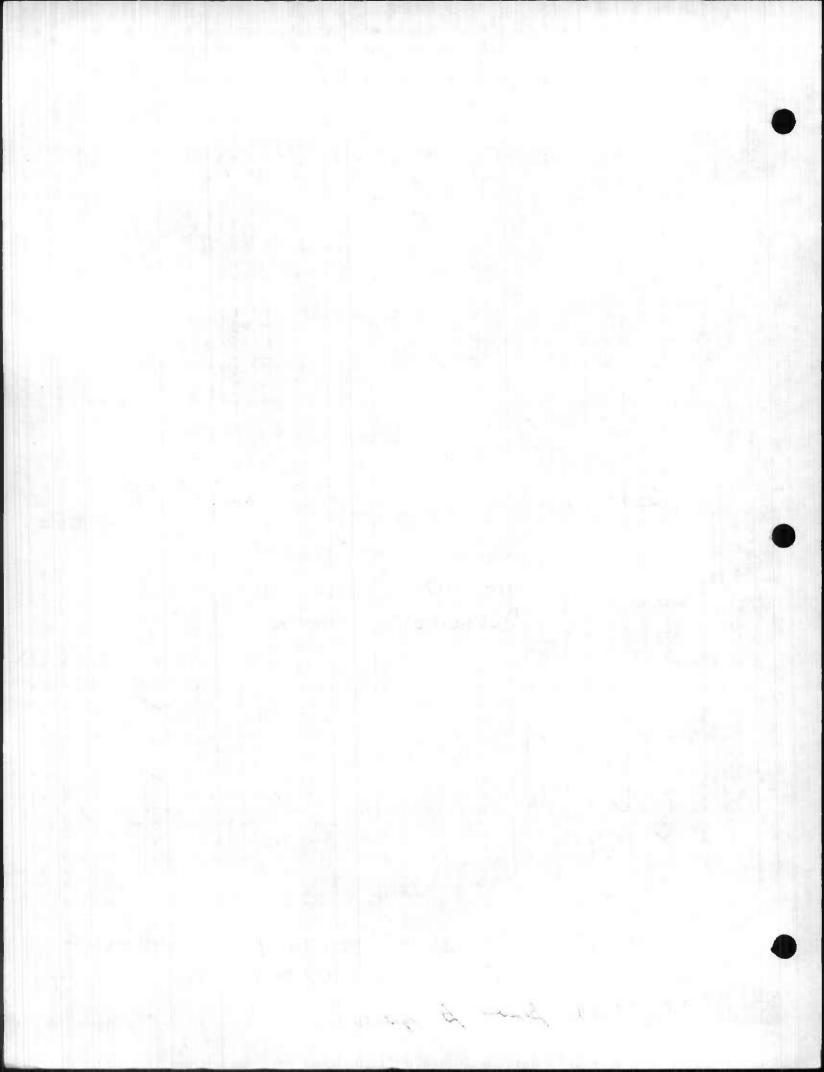
31. Date filed (Month, Day, Year) State FEB 1 7 2000 Registrar

MARGO

32. Registrar's Signature

MENENDEL M.D.

parks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Charles Hudgins 0330 February 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Johns Hopkins Bayview Baltimore N/A If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year)
July 13,1918 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Months Days 1 NM 2 F 212-12-0416 81 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5807 Cedonia Avenue 21206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Nes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Electrician Esskay 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Carlos Hudgins Lena Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Santina Hudgins/Wife 5807 Cedonia Avenue Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 2/15/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eurife's Service Licenses 22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Coronary artery disease

Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) Gastroin testinal bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? Chronic renal failure 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to Chronic anemia 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Box 68760. Division of Vital Records, P.O.

/Medical Examiner ician and burial-transit The law requires that the death certificate be executed the 58 for use page 2 or Attending Physician: this funeral After r death. 24 hours after deat Puneral Director: filled in by the Hospital within 24 hor To the Fune completely fi 10

Physician/Medical Examiner þ Completed Be Certification: To edicai

Physician

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Hygiana.

Pages 1 and 2 should be fit threat of Health and Mental Health and Mental Health and Italian 27 is marked oth jury or other traumatic event

Physician

Saltimore, Maryland 21215-0020

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State Registrar

31. Dete filed (Month, Day, Year) FEB17 2000

29b. Signature and title of certifier

11 Elue

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)



5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature



28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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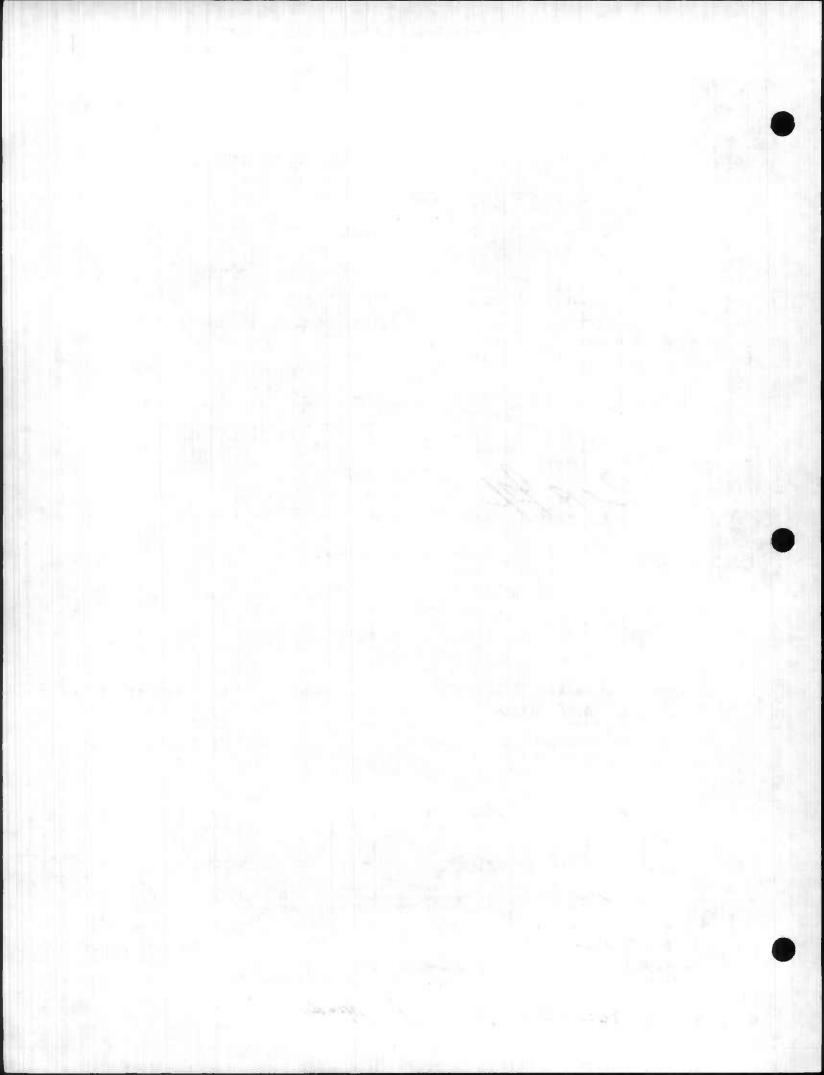
1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February 13, 2000



Physician /Medical Examiner

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Physician

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ent; if Item 27 is marked other than "net ary or other traumatic event, the Medicary or other traumatic event, the Medicary

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra

hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examiner þ Completed 8 Certification: To

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

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25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of tnjury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending 1 Yes 2 No invastigation 3 Suicide 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

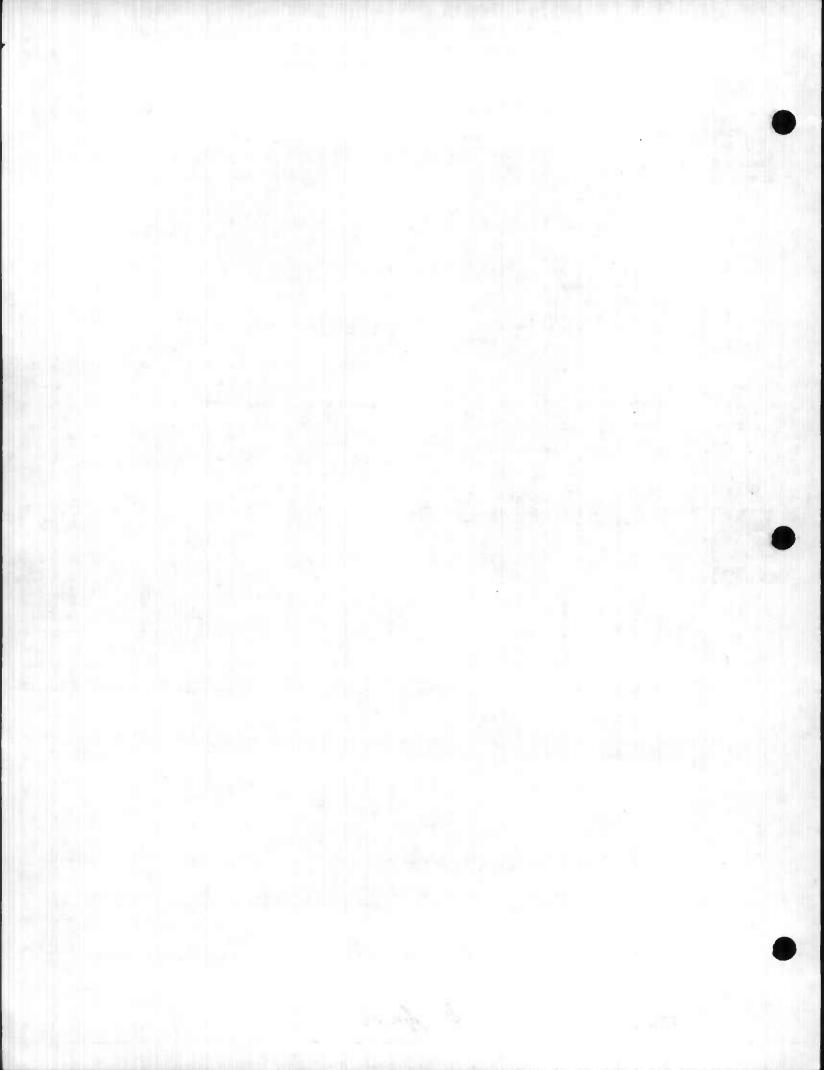
29b. Signature and title of certifie

wson who completed causa of death (Itam 23a) (Type, Print) me and address of

Ohn Stokes 3333 N. Calvert ST Balto 31. Data filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

FEB 1 7 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death 4c. Jounty of Death 6:21 A.M. rudry15 4b. City, Town, or Location of Death Name (If not institution, give street and number) 9506 ROAD ANCA 115 town
If Under 24 Hrs. 8, Date of Bir Liber BALTIMORE 5. Social Sacurity Number If Under 1 Year Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X**M 2□F Months Days Virginia Yrs. 215-60-0072 46 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Randallstown 10e. Straet and Number 10f. Zip Code 10g. Citizen of What Country? 7 Bannock Court 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forcas? 11/75-1 (X) Yes 2 □ No If Yes, Give Year or Dates: 6/77 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - Americen Indian, Black, White, etc. 11. Marital Status 1 Navar Married 2 Marriad Specify: Black 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 6/77 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest gr ede completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintance Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Walter Jones Helen Heath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Cynthia Jones / Wife 7 Bannock Court, Randallstown, Maryland 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other placa) 20c. Location - City or Town, State 1 Burlal 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest VA Ceme. 02/18/00 Owings Mills, Maryland Signature of Funeral Service Licensae 22. Name and Addrass of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland $_{21215}$ 23a. Part 1. Enter the disease, or complications that faulled the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on heart line. Approximate Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) eviosalavoi Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Moderately O 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performad? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Place of Death (Check only one) examiner2 Gricery Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Corner (Specify) 27. Manner of Dec 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Watural Injury

Physician /Medical Examiner

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Baltimore, Maryland 21215-0020

Director

Funeral

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Examiner Physician/Medicai ģ Completed Be

2 Accident

physician and s the buriel-transit The law requires that the death certificate be executed 68760 sign. page 2 Physician: Certification: To

P.O. Box Records, Division of Vital To the Hospital or Attending PP within 24 hours effer death.

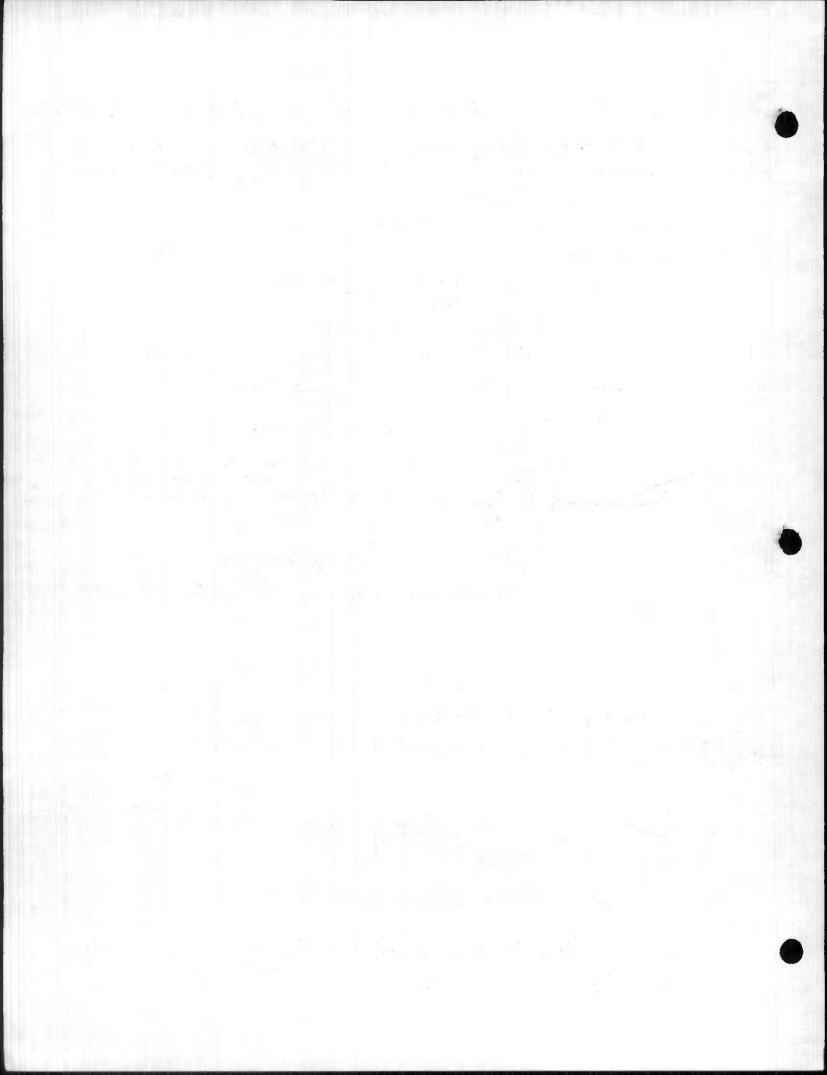
To the Funeral Director: After the completely filled in by the funeral

> State Registrar

6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 1 Carifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Dey, Year) ceuse of death (Item 23a) (Type, Print) more mid 31. Date filed (Month, Day, Yeer Registrage Signature

1 ☐ Yes



Piease Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Helen A. Jones February 10, 2000 1:33am 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Anne Arundel 609 Jones Road Severn If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birth Courte Peb. 10, 1906 Md. 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 XX 94 Months Hours 212-74-4708 Yrs **Usual Residence of Decedent** 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Arine Arundel Severn 1 ☐ Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 Jones Road 21144 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married **Black** 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) mentary/Secondary (0-12) 6th Grade Seamstress US Govt. Fort Meade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Snowden Annie Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kenneth R. Jones son 485 Oueenstown Road Severn, Md. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park Feb.15 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Zutter Herber 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Ras Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 503 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2010 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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Physician /Medical Examiner

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Department of Health and Mental hygiena.
Important: If Itam 27 is marked other than "natural", or Itam
any injury or other traumatic avent, the Hedral Frammers

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Examiner physician and the burial-transit by Physician/Medical for use as cate has been significant page 2 should b Completed Be Certification: To

The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. or Attending Physician: After this the funeral 24 hours after death.

Funeral Director: A filled in by Hospital completely

Medical To the Within 2 Registrar

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

31. Date filed (Month, Day, Year) FEB

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29b. Signature and title of certifier

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

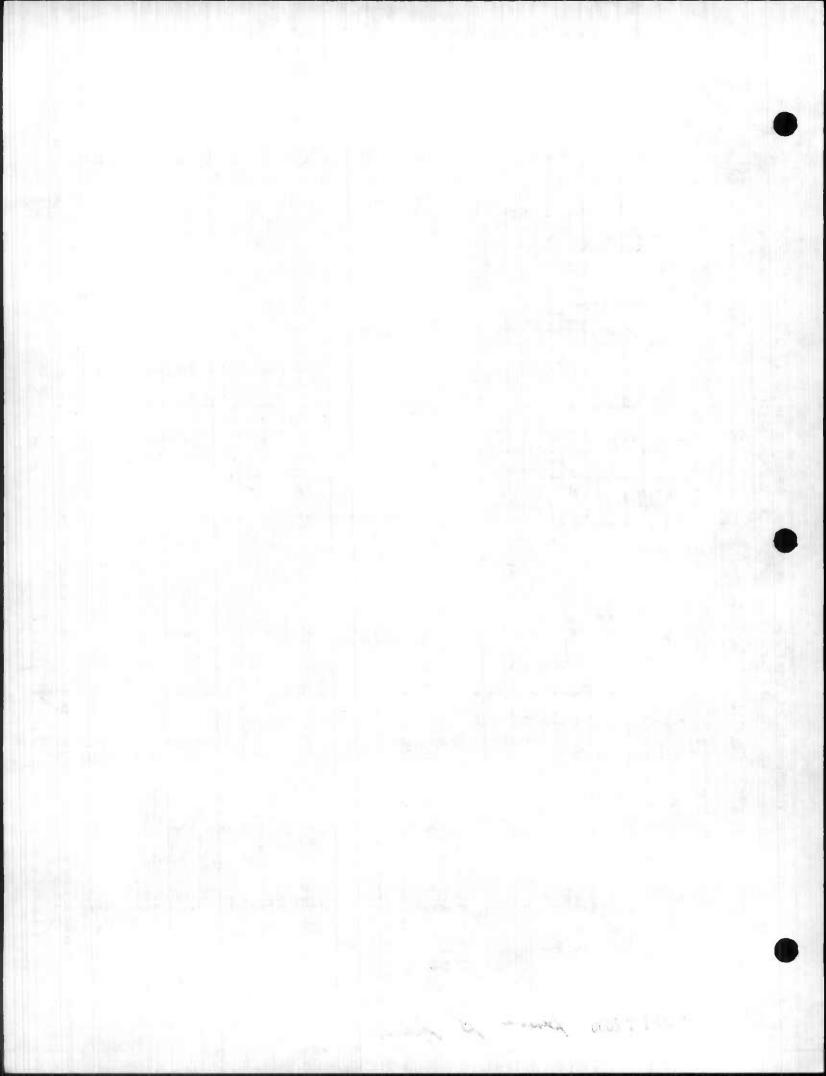
(Check only one)

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signeture

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stanley Jewett Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jewett **Physician** Stanicy 1215am /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death Examiner City Johns Hopking Bayview redical center Baltimore City Baltimone # Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey. Min. | May 25 Birthplaca (Stete or Foreign Country)
 MD 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F 69 Director 220-26-7181 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ahous 1 ☐ Yaa 2 ☐ No MD Baltimore County Dundalk Director Nerna 23a or 28e-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code TISA 21224 1046 Old North Point Rd Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? Race - American Indian, Bleck, White, etc. hours after 1 Never Merried 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give b altimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White 3 ☐Widowed 4 ☐ Divorced natural. Yaar or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Self-employed 11th Short Order Cook 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be nent of Health and Mental Department of Health and Monta important: If Item 27 is marked any Injury or other Unknown Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 250 S. President St, Unit 1303, Balto, Md21202 Victor Cheswick (Nephew) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 2000 Febll 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Ramovel from Stete
4 Donetion 5 Other (Specify) MetroCrematory, Inc. Catonsville, MD 21. Signeture of Funerei Service Lion 22. Name and Address of Facility Chavis Funeral Home 1)24 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellura. List only one cause on each line. 21231 **Physician** /Medical Immediete Cause (Finel preumonia /day diseesa or condition resulting in death) Examiner Due to (or es a consequence of): Examiner physician and the buriel-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical the Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heute Renal Failure been signed the should be det by Records. Be Completed 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? within 24 hours after death.
To the Funeral Director: After this completely filled in to the 1 Yes 20 No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred 1 Netural 5 Pending 1 Yes 2 No 2 Accident investigetion 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stele) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02/06/00 VI Cherda, M.D

State Registrar 31. Dete filed (Month, Dey, Year)
FEB 1 7 2000

Sandry Chendra

32. Registrar's Signeture

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Sparks

4940 Eastern Avenue

Baldinone, mo2/22 y

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Year Winifred Jenkins FEBRUARY 11. 2000 3:07 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Saint Joseph Medical Center Towson Baltimore H Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. Month, Day, Year) 99. Birthplace (State or Foreign Baltimore City, Md. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Days Months 214 14 2183 1□M & F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Maryland Baltimore Baltimore County 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 7929 Rolling View Avenue 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black White etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: White 3√Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 N/A National Security Agency Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) William Biddison Annetta Burnham 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy Doyle 4415 Mary Avenue Baltimore, Md. 21206 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 □Other (Specify) Parkwood Cemetery February 14, 2000 Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22. Neme and Address of Fecility Baltimore, Maryland 21236 27401 Belair Kd. Lassahn tuneral Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervai Between Onset end Deeth Immediate Cause (Finet SMALL CELL CANCER OF LUNG MONTHS diseese or condition resulting in death) Due to (or es e consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PANCYTOPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? RENAL FAILURE

Physician /Medical Examiner

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Division of Vital or Attanding Physician: after death.

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altimore, Maryland 21215-0020

Director

Funeral

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Medical Certification: To in 24 hou. the Funeral Dire.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

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25. Was cese referred to medicel axaminer?
1 Yes 2 No 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Inpatient 2 ☐ ER/Outpettent 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

27. Manner of Death 1. Neturat 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident

3 Suicide 6 Could not be determined 28t. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and mannar as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier

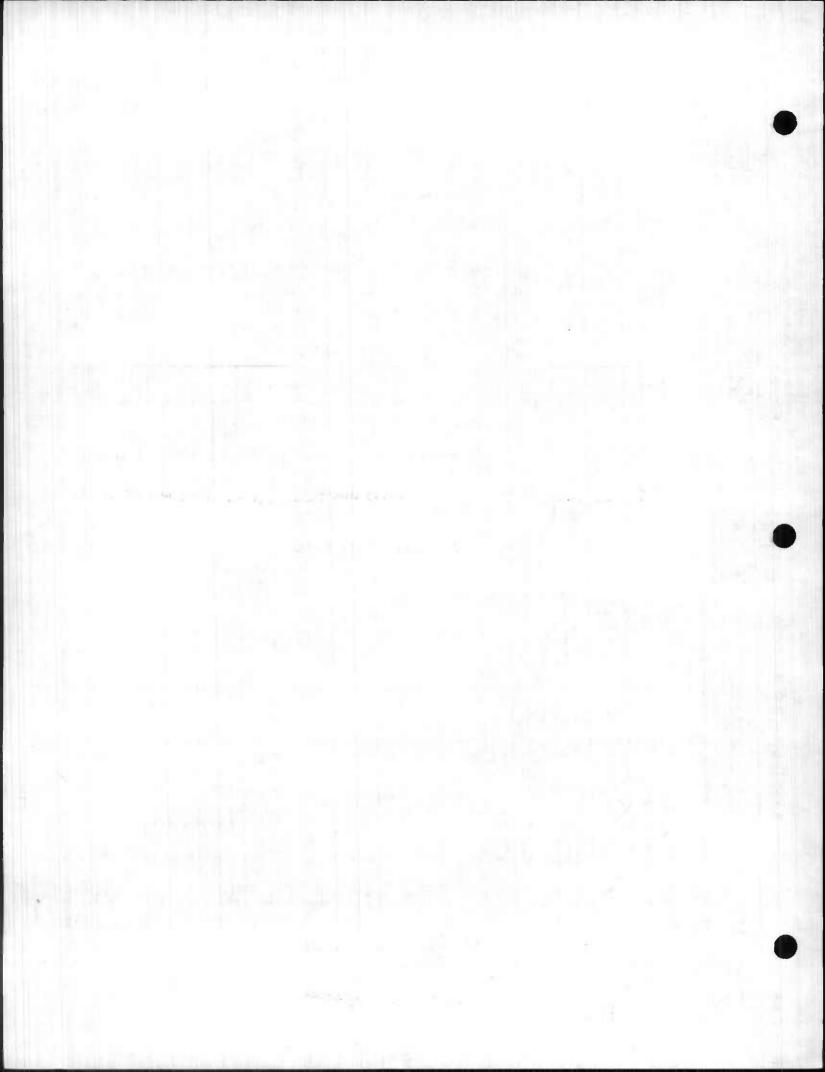
29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier MU 29c. License number 2-14-2000 14thicum D 31826

30. Nama and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

LINTHICUM, M. D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date liled (Month, Dey, Year)

State Registrar

32. Registlar's Signature FEB17



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 49 7

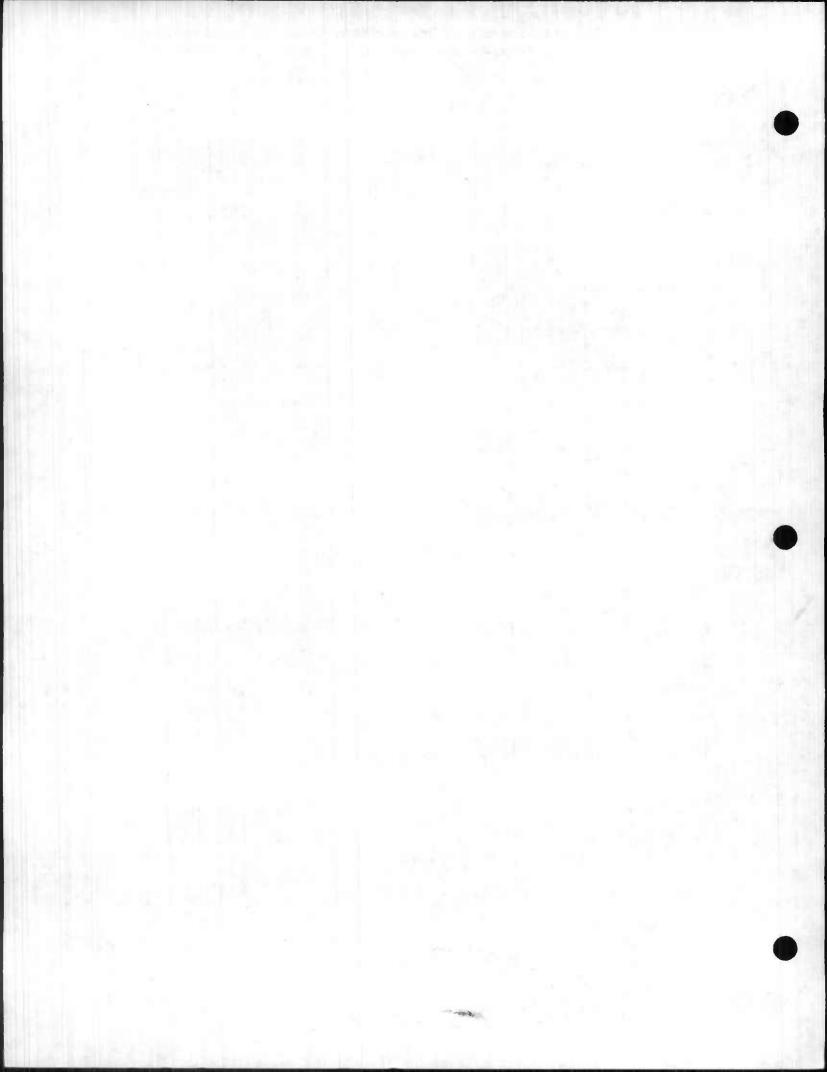
Certificate of Death

				Certifica	te of	Death		Reg. No.		
6.	1. Decedent's Name (First, Middle, L						2. Date of D	eath Day	Year	3. Time of Death
Physician /Medical	Catherine E. K	opera					FEBRUAR			7:00 AM
Examiner	4a Facility Name (If not institution, g	ive street and number)					or Location of Dea		y of Death	
	Saint Joseph				- 1 V	T O W			Balti	
uneral irector	216-03-4124	Sex 1 M 2 F 7. Age	e (In yrs. last bi	Yrs. Months	Days		Hrs. 8. Date of B Min. Month, C	7 1906	9. Birthpli Count MD	ace (Stete or Fore try)
100	Usual Residence of Decedent 10a, State 10b, County		10c. City, Tov	m or Location					10	Od. inside City Limi
of all all		nore City		more Ci						12 Yea 2 □ 1
be notified Director	10e. Street and Number	more orey	Daiti		ip Code			10g. Citizen of	What Count	10.7
23a or unt be ral Dir	1534 Oak Ridge	Road			2121	8		USA	WHE COUNT	
at, or terms 23a or 28a-f shor Examiner, must be notified at by Furneral Director	11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:				Hispanic Origin lan, Mexican, P Specify:	7 (Specify Yes or N uerto Rican, etc.)	Ble	ca - America ack, White, e fy: Whit	etc.
ted best	15. Decedent's I		168	. Decedent's Us	ual Occu	pation during most of	warting	16b. Kind of I	Business/Ind	ustry
completed	(Specify only highest g Elemantary/Secondary (0-12) 8 th	College (1-4or 5	+) S	eamstre	use retire	iduring most or id)	WORKENG	Factor	y Work	cer
	17. Father's Nama (First, Middle, Las	ot)				18. Mother's	Nama (First, Middl	e, Maiden Surna	me)	
matic sver	Frederick Pess	saro				Mar	У	Fermes		
t ji	19a. Informant's Name/Ralationship Kathleen Eagers	(Type, Print) (daughter)	191				r Rural Route Num et, Balti			
or other tr	20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3	□Removal from State	cemete	of Disposition (Na ary, crematory or	ame of other pla	ice)	Date	20c. Location	- City or Tov	wn, State
lury	4 Donetion 5 Other (Spec		New C	athedra				Baltimo	re Cit	:y, MD
any injury once.	21. Signature of Funeral Service Lice	n see					feld Home		21212	
	23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused	the death. Do						1	Approximata Intarval Batween
ician dical	Immediete Causa (Final	ACUTE I		ד ומדמ	NEO	OCT TON			1	Onset and Death MINUTES
niner	disease or condition resulting in death)	8	V 1 - 1	consequence of		ACT TON			1	LITIAM I me
ě			Due to (or as a	consequence of	,				1	
ial-transit Examiner	Sequentially list conditions, if any, leading to immediate	b	Due to (or es a	consequence of):					ME
edical	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or as a	consequence of	:					- 39
5 6 5		d								
ed for	Part II. Other aignificant conditions	contributing to death bu	rt not resulting i	in the underlying	cause gi	ven in Part I.	23b. Die	i tobacco use c	ontribute to	the cause of dear
be detached for use	ACUTE RENAL FA						10	Yes 2 No	3 Prob	ebly 4 Unknown
should	POSSIBLE RHABI	OOMYOLYSIS						s an autopsy formed?	con	ora autopsy finding illable prior to inpletion of cause death?
Comp	INSULIN DEPEN	NDENT DIABE	TES MEL	LITUS			10	Yes 200 No		Yes 2 No
director, pag	25. Was case referred to medical axaminer?	Moonitel			100		Death (Check only	one)		
0 0	1 Yes 2 No	Hospital: 1 (Inpatie		-	UA		ng Home 5 Re)
To the Funeral Director: After completely filled in by the funer Medical Certification:	27. Manner of Death 1 Natural 5 Panding 2 Accident investigation		Year) 280.	Time of Injury M	28c. Inju Wo 1	ryat rk?]Yes 2 ☐ No	28d. Describe	how injury occu	irred	
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not datarmine		iry - At home, for :. (Specify)	arm, street, facto	ry, office			(Street and Nun own, State)	nber or Rural	Route Number,
To the Funeral I completely filled Medical Ce		hysician: To the best of miner: On the basis of and manner sta	axamination ar							
Ne We	29b. Signeture and title of certifier	2 1	10.1	25	c. Licen	se number		29d. Date sign	ed (Month, L	Day, Year)
10	1	hed	69		D48	271		02 -	15-	00
600	30. Name and addrass of person who	completed causa of de	eath (Item 23a)							
		1. D. 7601	OSLE	RDRIV	E S	-411, T	OWSON, M	ARYLAN	21	204
State	31. Dete filed (Month, Day, Year) FFR 1 7 2000	32. Registra	ar's Signaldre	spark	2					

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Luc	dwig	V.		Kauder	s Jr.			11,2000	Year	12:20pm
Medical xaminer	4a Facility Na	me (If not institution, give	street and number)				own, or Locatio		4c. County		
	1723	3 Lydonlea W	ay			Ba	altimor		N,	/A	
neral ector		-28-0884	X 7. Age XIM 2□ F	(In yrs. last bi	Yrs. If Under 1	Yeer If Under Days Hours	24 Hrs. 8. 0	Nate of Birth Month, Pay, 5-11-	Year) -31	9. Birthp Coun	lace (Stata or Forei try) MD
1	Usual Reside 10a, State MD	10b. County N/A		10c. City, Tow	on or Location Baltimor					1	0d. Inside City Limit
notthe	10e. Street ar				10f. Zip C			11	Oa. Citizen of W	hat Coun	1 X Yes 2 □ N
free met be nother Funeral Director		3 Lydonlea W	ay			2123			US	SA	
à à		etus Married 2 Married Divorced	12. Wes Decedent E Armed Forcas? 1 X Yes 2 □ N If Yes, Give Year or Dates:	0	13. Was Decede if Yes, specif	int of Hispanic Or by Cuban, Mexica No Specify		Yes or No- n, etc.)	Black	e - Americ k, Whita, whi	
Be Completed		15. Decedent's Edi (Specify only highest grad	le completed)	168	a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during mos retired)	st of working		16b. Kind of Bu	siness/inc	dustry
E	Elementery	/Secondary (0-12)	College (1-4or 5-	+)	Service	Advisor			Lincoln	n Mer	cury Deal
0 0		ame (First, Middle, Last) Ludwig V. Ka	uders Sr.	,		- v	er's Name (Fir	st, Middle, I	Maiden Surnam		
T. T.		nt's Name/Relationship (7)		19	b. Malling Address (Street and Numb				Stata, Zip	
y or other		of Disposition I 2 X Cremetion 3 I tion 5 Other (Specify)		cemete	ol Disposition (Name ery, crematory or off Metro Cre	e of ner place)	D		20c. Location -		
Per a		on Suneral Service Licens			22. Name and	Address of Facil	ity				7 . 2
BUC	61		2 7 01	0.	Cvac	h/Roseda	ale Fun				
	23a Part1 F	nter the disease, or compor heart failure. List only of	lications/that caused	the death Do	not enter the mode	hesaco A	Ve. Ro	sedale	est.	21237	Approximate
ian	shock, o	or heart failure. List only o	one cause on each lin	е.	1					-	Interval Between Onset and Death
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iner	resulting in d	eath)	a. // >//	Due to (or as a	consequence on:	10000				1	/ / / /
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edical	Sequentially if any, leading cause. Enter Cause (Diseathat initiated resulting in de	events	, /	//		menti,	0-				> 5 445
edical	Cause (Disea that initiated resulting in d	events eath) Last	. Vasc	ula	L De						
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nould be detacted for use as the but steed by Physician/Medical	Cause (Disea that initiated resulting in d	events eath) Last	. Vasc	ula	L De		1.		aa 2 No	3 ☐ Pro	o the cause of death bebly 4 Unkno
hould be detached for use as the bur eted by Physiclan/Medical	Cause (Disea that initiated resulting in d	events eath) Last	. Vasc	ula	L De		1.	1 □ Y 24a. Was a	an autopsy med?	3 Pro	bably 4 Unkno
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Year HANNAH 2 0200 AM 10 2000 KOTZIN 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE NORTH OAKS NURSING CENTER If Under 24 Hrs. 5. Social Security Number If Under 1 Yaar 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Months Days Hours 1□ M 2X F 214-05-1908 88 OCT. 8, 1911 MD Usuel Rasidenca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo BALTIMORE BALTIMORE 10e Street and Number 10g. Citizen of What Country? 10f. Zio Code 725 MT. WILSON LANE 21208 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Merital Status 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yas 2 X No If Yas, Giva 1 Yas 2 No Specify: Specify 3 Widowed 4 Divorced WHITE Yaar or Datas: 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Bustness/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) PROPRIETOR S. KOTZIN COMPANY 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) SAMUEL KOTZIN CECELIA KATZ 19a. Informant's Name/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) SHEILA STEELMAN / NIECE 11 BRICKFORD LANE - BALTIMORE, MD 21208 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Removal from State KNESSETH ISRAEL CEMETERY 2/18/00 ANNAPOLIS, MD 4 Donation 5 Other (Specify) 21. Signatura of Funerel Sarvice Licensee 22. Neme end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediata Causa (Final resmonia 2 DAYS diseese or condition resulting in daath) YEARS MOKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Dua to (or es a consequança of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 2 No 1 Yas 2 No 25. Was case refarred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be 3 Suicida 28a. Pleca of fnjury - At homa, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida

Examiner physician and the burial-transit The law requires that the death certificate be executed P.O. Box 68760. Physician/Medical 2 signed bed bed Records. þ Completed page 2 Division of Vital or Attending Physician: after death. Director: After this certifice director. Be funeral

Certification: To

Physician

/Medical

Examiner

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Funeral

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Important: If Ilam 27 any injury or other in

Physician /Medical

Examiner

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Completed

Be

the Maryland

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

altimore, Maryland 21215-0020

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State Registrar

29a, Certifier

Medical

29b. Signature and title of certifian

29c. Licanse number

1st Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and dua to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end mannar stated. 29d. Date signed (Month, Day, Year)

MD 30. Name and address of person who complated causa of death (ttem 23a) (Type, Print)

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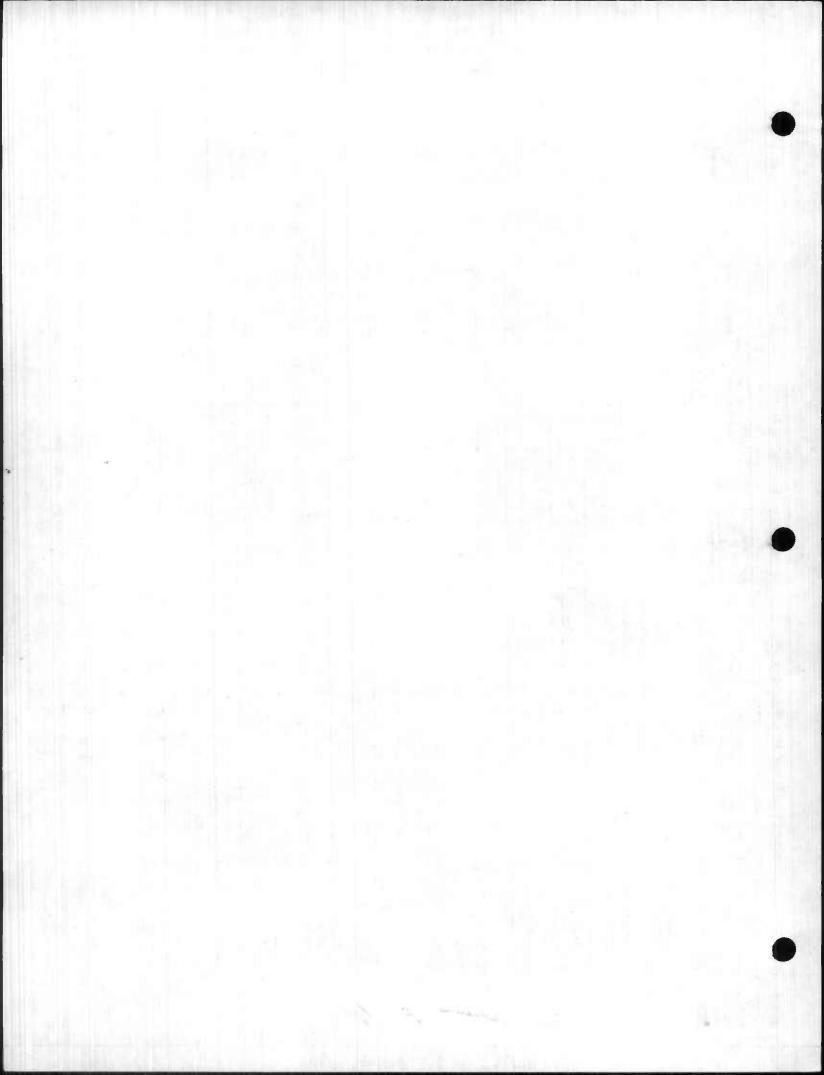
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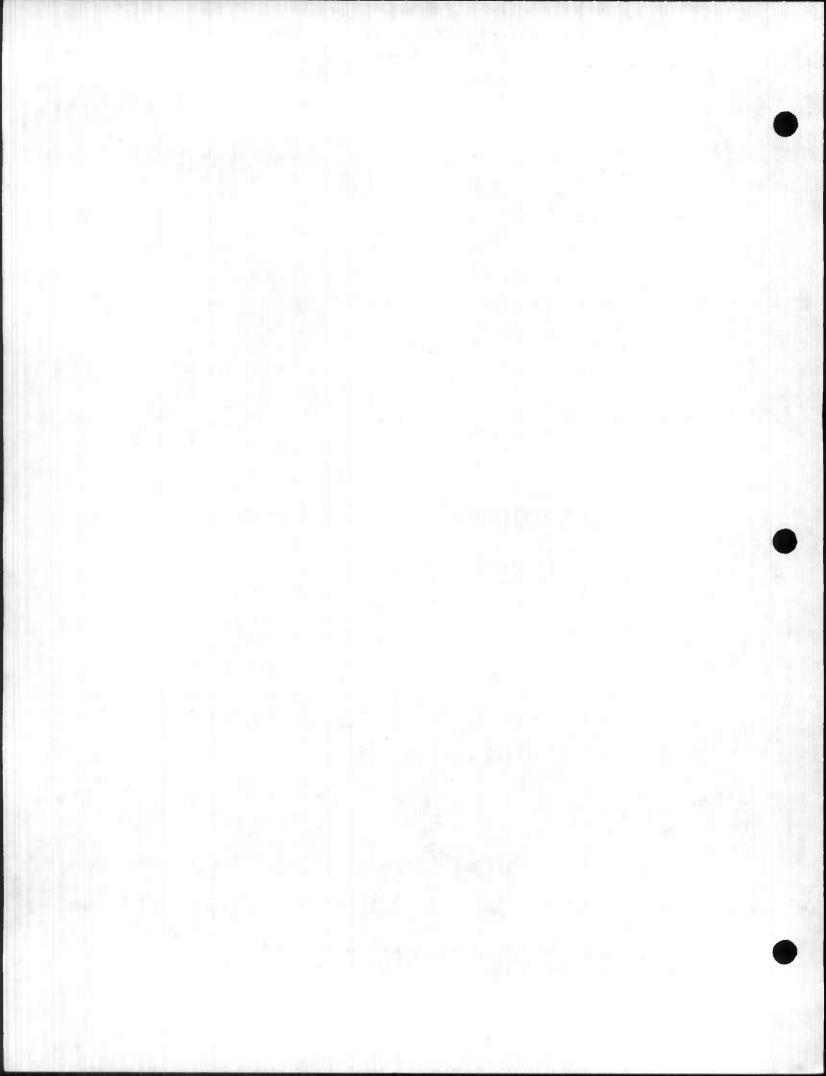
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31. Data fited (Month, Day, Year) FEB 1 7 2000 32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

RBAN Security Numb 32-6338 sidence of Dec e 10 BF el and Number SOUTH al Status dever Married Vidowed 4 □ 15. (Specify of ontany/Secondan 12 or's Name (Firs AHAM Ammant's Neme Burial 2 □ Cr Donalion 5 □ alure of Funera 11. Enter the dick, or heart fail te Cause (Fins or condition in death)	HOSPI ber 6. 8 scedant be. County ROWARD or OCEAN 2 Married Divorced Decedent's Eonly highast gray (0-12) st, Middle, Las Reletionship FF, DAUC disease, or conditure. List only	DR . APT. 12. Was Deceramed For 1 Yes If Yes, Give Year or Da College (1- (Type, Print) GHTER SAREL	7. Age (In yrs. 92 10c. Cit HA 8Q dent Ever in U ces? 2 N No e states: 40r 5+) ZUCKER KROMER 200. F MT	y, Town or Lo LLENDA 16a. Decec (Give iife. I EXECU 19b. Mailir 3538 Place of Dispo permetery, crar MORIA 22 h. Do not ent	Months Calion LE 10f. Zig 330 Was Dece fres, special Section of we special Section of Section of Section of Section of Section of Section of Section	r 1 Yaar Days Do Coda DO 9 deni of Heify Cuba 2 No all Occuppork dona a retired s (Street BINE me of other place	18. Molher's Nam SARAH and Number or Bu	s. Date of Bir MAR 11 30 Decify Yas or No Rican, etc.) Decify Yas or No Price Number of Chase 2/16/00 Dete	10g. Citizen of V USA 14. Race Blace Specify 16b. Kind of Bu SECURITY Meiden Surnam MARCO or, City of Towas 20c. Location FAIRVIE	of Death MERY 9. Birthpla NEW 10c Vhat Country 1 - Amaricar k, White, et WHITE Islness/Indu Y City or Tow W, NJ DS IN MD 2	n Indian, c. Sistry
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Injury at Work? 1 Yes 2 No Suicide Homicide Occurred to the time, date and place seck only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place seck only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the content of the place of Injury - All home, farm, streat, factory, office	cese referred to medical inter? Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Resident Suicide Accident Suicide Homicide Suicide Homicide Suicide Homicide Suicide Accident Suicide Homicide Suicide Suicide Suicide Homicide Suicide Suicide Suicide Homicide Suicide	Case referred to medicel 1 Yes 2 No No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other Natural Suicide Suicide Could not be determined 28a. 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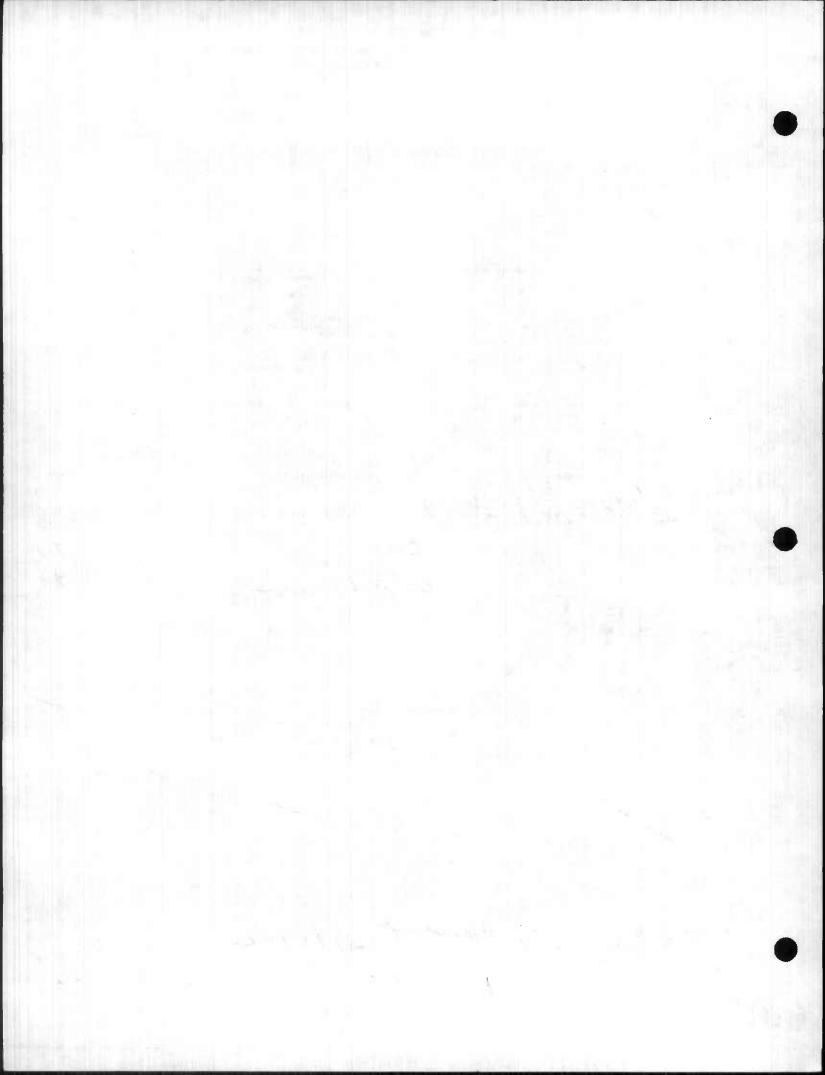


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State of Maryland	Department	of Health	and	Mental	Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROLSTON CARROLL LORENZ 02 13 2000 10:05 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CATONSVILLE COMMONS NURSING HOME CATONSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 15 M 2□ F 95 216-03-9858 Director 06-14-1904 MARYLAND Usual Residence of Decedent 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE TOWSON 1 Yes 2 No Director 28a-f: 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ď 908 LOCUSTVALE ROAD 21204 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 ▼ Married natural, or 21215-0020 1 Yes 2 No Specify: WHITE Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SELF EMPLOYED Elementary/Secondary (0-12) College (1-4or 5+) INTERIOR DECORATION INTERIOR DECORATOR Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental JOHN LORENZ CARRIE STRAUSBURG 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 508 CLEVELAND ROAD, LINTHICUM, MARYLAND JOHN D. LORENZ NEPHEW mportant: If Item 27 iny Injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 02-16 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremetion 3 ☐ Removet from Stete TAYLORSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) TAYLORSVILLE UMC CEMETERY 2000 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** CMF /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown ò hypothypeidige 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medicat examiner? 8 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending 1. Neturel 5 Pending Investigation ne Hospital or Attending n 24 hours effer death. The Funeral Director: After 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Cortifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) To the To the To the F 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1009 FREDERICK ROAD, BALTIMORE, MD BIPIN Κ. TURAKHIA M.D. 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar



ED IT	EMS 25,26	,27,29a PER MD G780 2,		Ce	rtificate	e of	Death			Reg. No.		
	Physician /Medical	1. Decedent's Name (First, Middle, LeRoy C. Lauc							2. Date of D Month Januar	Day	Year 2000	3. Time of Death 5:55P
	Examiner	4a Fecility Neme (If not institution,					4b. City, To	own, or Lo	ocation of Dec		unty of Death	
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	Funeral		Sex 7. Age (In y	rs. last birthday,	If Under				8. Dete of 8 (Month, L	lirth	9. Birth	placa (State or Foreig
	Director	217-36-4303	1⊠M 2□F 72	Yrs.	WO III IS	Days	110013		March	5,1927		cimore MD.
2		Usual Residence of Decedent		0: 7 1								
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£	or 2	10e. Street and Number			10f. Zip (Code				10g. Citizen	of What Cou	ntry?
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Ma	then trau	Mrs.Louise Laude								MD.211		0000)
0 5	Health Item 27 other tr	20a. Method of Disposition		. Place of Disp	osition (Nam	e of		erry	Date .	T	ion - City or T	own. Stete
Baltimore,	ant of ry or o	1 Buriel 2 □ Cremetion 3		cemetery, cre					10.1000			
tin	ritme	4 Donetion 5 Other (Spe		arkwood					:/3/200	Raiti	more, M	aryland
Balt	Department of Amportant: If It any Injury or one	21. Signeture of Funeral Service Like	Dog /		2. Neme and				1 Home			
- 1	th	16,70	rassahx		11750	Bel	air F	Road	Kings	ville.	MD.210	87
4		23e. Part1. Enter the diseese, or co shock, or heart failure. List or	omplications that caused the di ly one cause on each line.	eeth. Do not en	ter the mode	of dyi	ng, such es	cardiac	or respiratory	arrest,		Approximate triterval Between
	hysician										i	Onset and Death
	/Medical	tmmediata Cause (Final disease or condition	RESPIR	4TUR	4 1	FA	ILLE	RE			i	
-		resulting in death)	Due to	o (or aa a conse								
7			COR	PUL	MON	AL	E					
cute	g physician and as the bunal-transit fedical Examir	Sequentially list conditions,	Due to	o (or es e conse	quence of):							
0,	ician s burial-	Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events										
68760,	physic s the b	thet initiated events resulting In deeth) Last	C. Due Id	(or es e conse	quence of):							2 1
Box 68760,	e attending physician and to ruse as the bunk-transit is clary Medical Examiner	THE STATE OF THE S										
Box	attending for use as		d	-							1	
. 60	5 de 10	Pert II. Other algorificant conditions	contributing to death but not	resulting in the u	inderlying ca	use oi	ven in Pert	t.	23b. DI	d tobacco us	contribute 1	to the cause of death

Division of Vital Records, P.O.

Laudenklos, heroy C.

To the Hospital or Attending Physician: The law requires that the within 42 hours stated death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. Be Completed by Phy.

MORBID OBESITY 25. Wes case referred to medicat examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Neturel 2 Accident

3 Suicide 4 Homicide

Medical Certification: To



29e. Certifier (Check only one) 1KKCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Panding investigation

6 Could not be determined

29c. License number

1 Yes 2 No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 20 No

1□ Yes 2 No

28d. Describe how injury occurred

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospitel:

1 Inpatient

28a. Date of Injury (Month, Day Year)

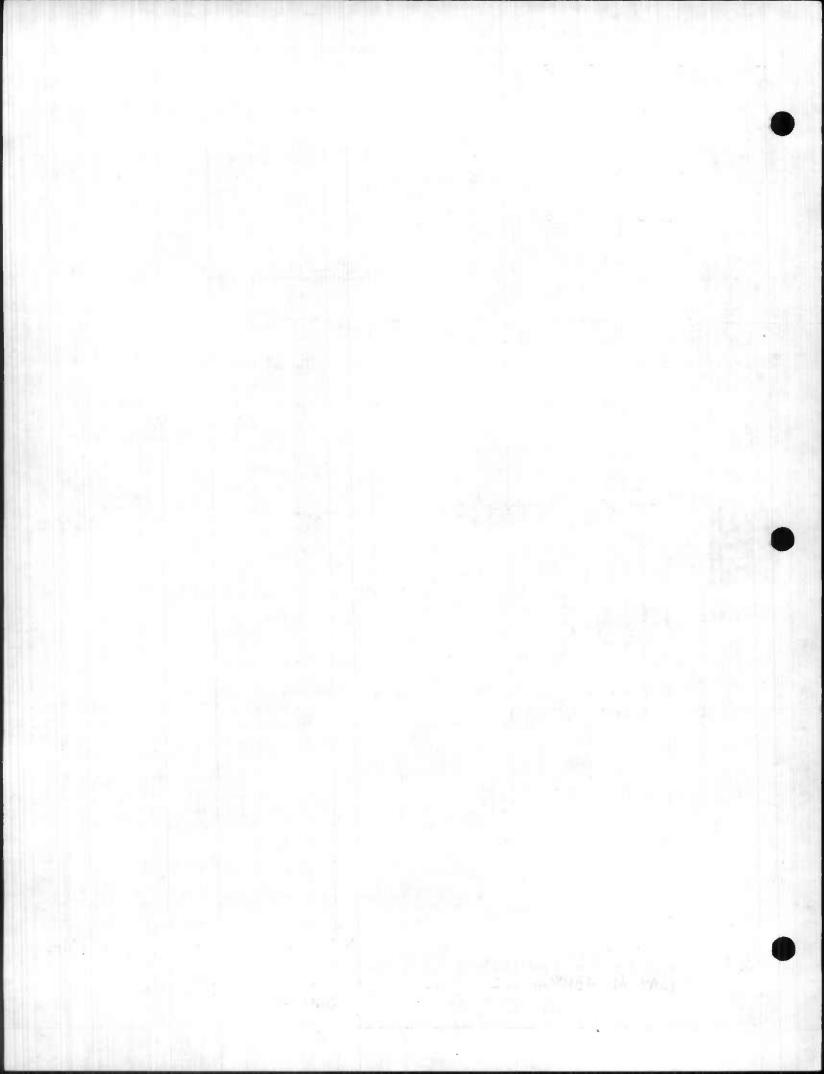
& NORTH MD

2☐ ER/Outpatient 3☐ DOA

28b. Time of

28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify)

State Registrar

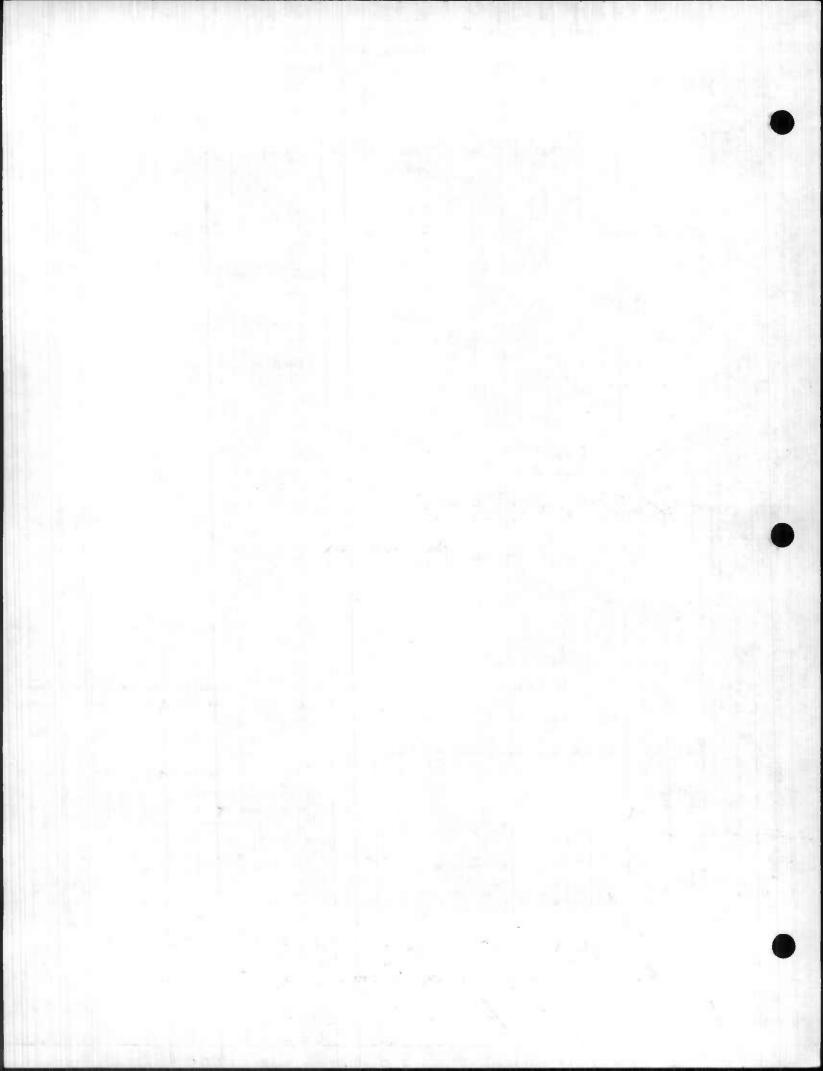


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 1, 9 2 3

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6:15 pm KATHARINE MILLER 02 13 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 719 MAIDEN CHOICE LANE, CATONSVILLE BALTIMORE APT. BR213 If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) PENNSYLVANIA 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🖾 F 160-38-1271 100 Yrs. Director 01-22-1900 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show MD BALTIMORE CATONSVILLE 1 ☐ Yes 2 No Director 288-1 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Nerna 23a or APT BR213 719 MAIDEN CHOICE LANE 21228 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 'natural', or 1 ☐ Yes 2 No Specify: Specify: WHITE altimore, Maryland 21215-0020 à 3 Widowed 4 □ Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 22 filled within Hygiene. ther then Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Health and Mental is marked LOUISA SCHNEIDER JOHN B. HOLVECK 2 19e. Informent'a Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Important: If Item 27 is any injury or other trace RUTH ANN CORNELIUS 719 MAIDEN CHOICE LANE, APT. BR213 BALTIMORE, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 02-18 cemetery, crematory or other place) 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 2000 SILVER SPRING, MD. GATE OF HEAVEN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 23a Part 1. Enter the disease, or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel outension WIELCS disease or condition resulting in death) Examiner Examiner ettending physician and for use es the bunal-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes A No signed b by 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed The law page 2 s 2/1 No 2 0 No certificate or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes No Other: 4 Nursing Home 52 Residence 6 Other (Specify) Certification: To this 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Affer A Natural 5 Pending s effer des. 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Dis completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MD February 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catorsville nosen 471.5 Maida Choice 711 lary 31. Date filed (Month, Day, Year) 32. Regultrar's Signature State Registrar **DHMH 16 Rev 6/95**

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Jan. **Physician** 26 Jessie Bell Munden 2000 10:58 PM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 720 60th Place Capitol Heights Prince George's If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day Feb. 26 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 10 M 20 F 225-09-3965 Yrs Feb. 1909 Little Wash., NC 90 Director Usuel Residence of Decedent with the Meryland 10a. State 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examinet must be notified at 10d. Inside City Limits MD Prince George's Capitol Heights N☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 60th Place 20793 U.S.A. permit. Peges 1 end 2 should be filed within 72 hours after death v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23s any injury or other traumatic event, the Modical Examples mans. Optice. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Eiementary/Secondary (0-12) Coilege (1-4or 5+) 12TH Homemaker Private 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Lathan Flossie Black 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Al Douglas/Grandson 720 60th Place, Capitol Heights, MD 20793 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) FT. Lincoln Cemetery 2/01/00 Bladensburg, MD 22. Name and Address of Facility Latney's Funeral Home, Inc. Gelney CCO348 3831 Georgia Ave., NW, Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Congestive Heart Failure Examiner Due to (or as a consequenca of) Hypertensive Cardiovascular Disease Examiner The law requires that the death certificate be executed physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Hypertension Box 68760, Physician/Medical Due to (or as a consequenca of) 189 esn signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. o 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes ZZ No 3 Probably 4 □ Unknown Arthritis Division of Vital Records. þ 24a. Was an autopsy periormed? 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed peen page 2 has certificate 1 ☐ Yes 2 No 1 TYes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 8 ☐ Other (Specify) 1 Yes 2√2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 00 DC MDJ5169 aluelu tome. 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Barrington B. Barnes, MD 1805 Benning RD., NE Wash., DC 20005 31. Date filed (Month State 2000 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 14 9 2 5 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middla, Last, 2. Data of Death 3. Time of Death Month Yaar FRANK MARTIN 2:25A FEBRUARY 13 2000 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death

Days

10f. Zip Coda

Baltimore
If Undar 1 Yaar | If Under 24 Hrs. 8. [

Hours

12

19

4c. County of Death

10g. Citizan of What Country?

Birthplaca (Stata or Foreign Country)

10d. Insida City Limits

Was 2 □ No

21215

21215 Approximata Interval Between Onset and Death

24b. Wara autopsy findings available prior to completion of causa of daath?

1 ☐ Yas 2 ☐ No

M.D.

Black

Physician /Medicai Examiner **Funeral** Director

Bon Secours Hospital

10b. County

NA

6. Sex

1**X** M 2□ F

5. Social Sacurity Number

10e. Street and Number

10a. State

Director

219-30-7618

Usuat Rasidance of Decedant

the Maryland 28a-fr must be n Nerris 23a "natural", or Item relical Examiner filed within 72 hours after the Medical vertile in Mental Hygiene. 127 le merked other than "r y traumatic aver-. Pages 1 and 2 should be fin ment of Health and Mental H tant: If hem 27 is marked oth jury or other traumatic even

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

of Vital Records.

Division

Physician /Medical **Examiner**

Department of Important: If any Injury or

The law requires that the death certificate be executed bunial-trensit Physician/Medical ate has been signed page 2 should be de certificate Hospital or Attending Physician: this illed in by the funeral Affer after death.

3456 Park Heights Ave Funeral U.S.A.

14. Race - American Indian,
Black, Whita, atc. 21215 12. Was Decedant Evar In U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yas 2 XNo If Yas, Giva Year or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) 9th grade Truck Driver Smelkinson Bros. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Joseph Martin Sr. Beulah Blackman 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20b. Placa of Disposition (Nama of cametery, crematory or other place)

3456 Park Heights Ave, Baltimore Md
20c. Location - City or Town, State Juanita Martin-Wife 20a. Mathod of Disposition Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata
Conation 5 ☐ Other (Specify) Arbutus Mem. Park 2-19-00 Arbutus, Md 21. Signature of Funaral Sarvica Lifenses 22. Nama and Addrass of Facility March F/H West 234 Fin I. Entar the disease, or complications that caused the leath. Do not anter the mode of dying, such as cardiac or respiratory arrast, Acquised Immuno dificioney Syndrale Immedial Causa (Final disaas or condition rasulting in daath) Examiner Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or tnjury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of geath? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Was an autopsy performed? 1 Yas 2 No Be 25. Was casa rafarrad to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ■ Inpatiant 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Mannet of Death 28a. Date of Injury (Month, Day Yaar) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 👺 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Medicai 29a. Cartifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 17537 1600 W. MOUNT Royal Ave, Balto MD 21217 mplated causa of death (Itam 23a) (Type, Print)

7. Age (In yrs. last birthday)

65

Yrs.

10c. City, Town or Location

Baltimore

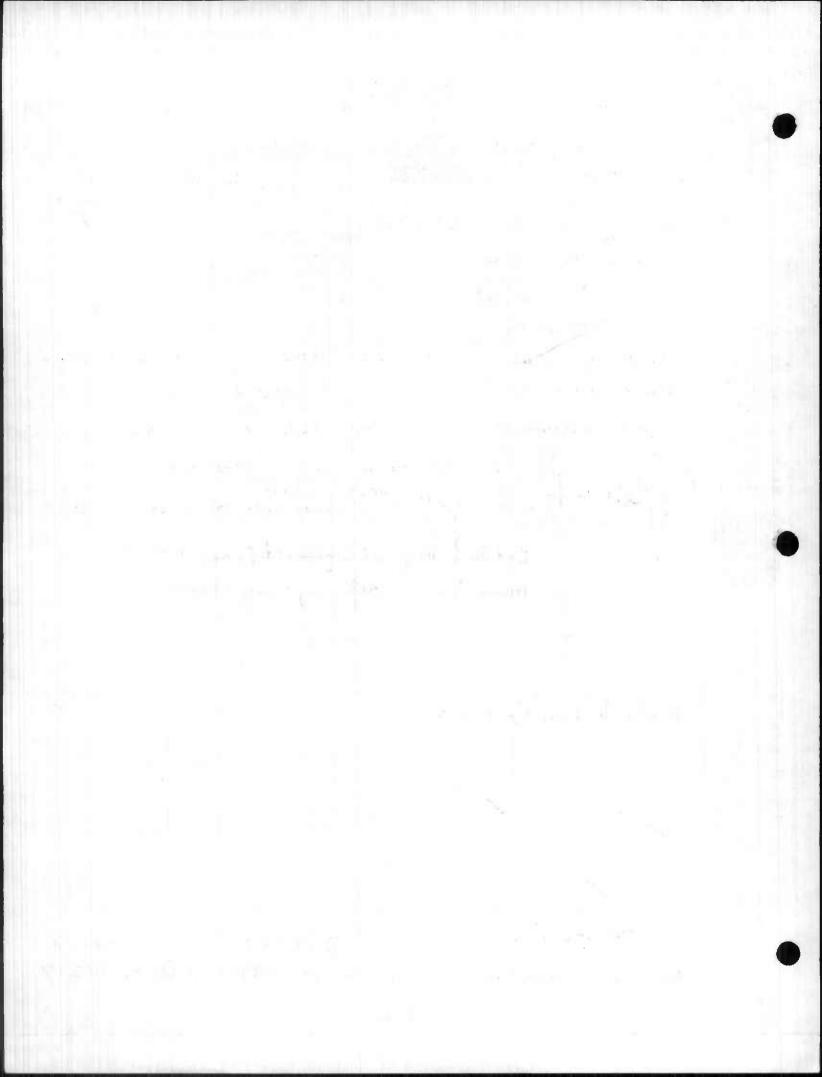
State Registrar

31. Data filed (Month, Day, Yaar) FEB 1 7 2000

32. Ragistrar's Signatura

24 hours a

To the Fune To the Fune completely fil



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State of Maryland / Department of Health and Mental Hygiene 9 2

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Angelina Mary Maranto February 11, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care - Old Court Randallstown Baltimore If Under 24 Hrs. If Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 X F 220-22-8547 85 Yes Director 3, 1914 Jan. Maryland Usual Rasidence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show or than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10912 Steffeny Road 21133 USA Funeral Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Peges 1 and 2 should be filed within 72 hours effer in ord of Healin and Mental Hybjere.

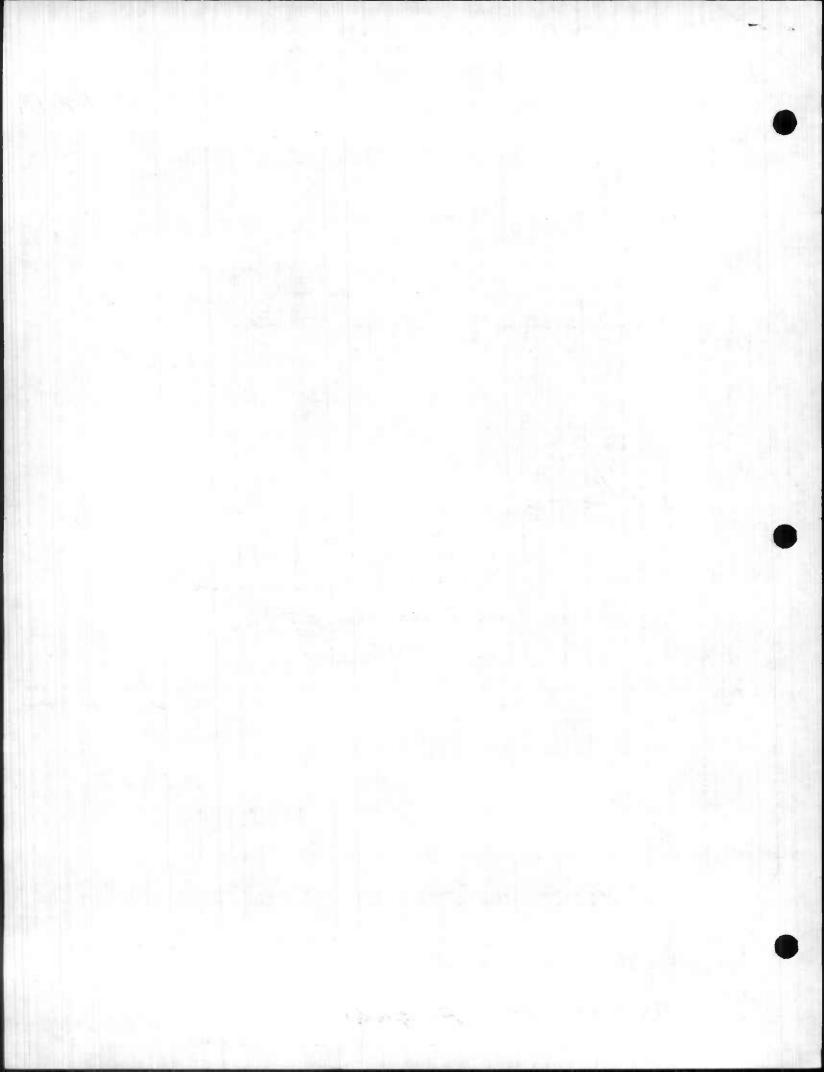
mr. If ferm 27 is merked other than "natural", or Nearly or other traumatic avent, the Mental Earn has any or other traumatic avent, the Mental Earn has 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify Specify: P 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 Years Office Clerk Manufacturing 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Maranto Teresa Difatta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Anthony Serio 10912 Steffeny Road Randallstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or Most Holy Redeemer Cem. 2/15/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Servica Licensee 8728 Liberty Road 21133 Randallstown, MD to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last and P.O. Box 68760. Physician/Medical USB 85 signed by the atte Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yaa 2 No Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 No certificate 1 Yes 1 □Yes 2 □ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 48 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Tima of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 29a. Certifier completely (Check only one) Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the Within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year) License number 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reisterstown Pd. * 108 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Ray 6/95

Registrar

7 2000

FEB 1



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 14927 State of Maryland / Department of Health and Mental Hygiene

Physical Benjamin Mrn 4s Facility Name (if not institution, pips stored and number) 4s Facility Name (if not institution, pips stored and number) 4s Facility Name (if not institution, pips stored and number) 4s Facility Name (if not institution, pips stored and number) 4s Facility Name (if not institution) 4s Facility Name (if not institution) 4s Facility Name (if not institution) 5s Social Security Number 5s Social Security Number 6s Soci		Cer	tificate of	Death	Reg	g. No.	
46 Feeling Name (Print Intelligence, give street and number) 700 South Philaded phila Boulevard 5 South Philaded phila Boulevard 5 South Philaded phila Boulevard 5 South Philaded philade					Month		3. Time of Death 1:50 A.M
Top Control		00 South Philadelphia Boulevard		Aberd	ocation of Death	4c. County of Death	
10. State 100. County Florence 100. County Florence 100. Experiment 100.		18-19-5651					nplace (State or Foreign untry) SC
SC Florence Florence Florence 106. Steel and Number 1921 West Canada Fore in U.S. 113. West Decoders Fore in U.S. 113. West Decoders Fore in U.S. 113. West Decoders for Manifest ("Discrete") Specific Florence ("Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants for U.S. 114. Race - American Indian. Black Whether Specific Plants f		The state of the s	cation				10d. Inside City Limits
11. Martial Status 11. Martial Status 12. Web Decodered Ever in U.S. 13. Web Decodered CP New Process 14. Race - American Indian, Martial Status 15. Decodered CP Married 15. Decodered Status Process 16. Brook Process 17. Father Name (Pirst, Middle, Last) 18. Brook Process 19. Martin Pr	ector	SC Florence	Florence	æ	T.o.		Yes 2□No
Specify Children Specify Spe			10f. Zip Code	29501	100		
19. Mother's Name (First, Middle, Last) 19. Mother's Name (First, Middle, Maidlen Summen) 19. Mother's Name (First, Middle, Maidlen Name (First, Middle, M	by	Nover Married 2 ☐ Merried 1 ☐ Yes 25 No If Yes, Give 1			pecify Yes or No- Rican, etc.)	Black, White	e, etc.
17. Father's Name (First, Middle, Masican Summan)		(Specify only highest grade completed) (Give I	kind of work done	e during most of work	king 16	6b. Kind of Business/I	ndustry
Wallace B. Minn, Sr. 19s. Informant's Name-Relationship (Type, Print) 19s. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wallace Minn / Father 20s. Method of Disposition 10s. Method of Disposition (Rurae of Date and Number of Rural Route Number, City or Town, State, Zip Code) 20s. Method of Disposition (Rurae of Date and Number of Rural Route Number, City or Town, State and Number of Rural Route Number, City or Town, State, Zip Code) 20s. Method of Disposition (Rurae of Date and Number of Rural Route, Rural Rural Route, Rural Route, Rural Route, Rural Route, Rural Route, R		Elementary/Secondary (0-12) College (1-4or 5+)		90)	I	ndustrial (c	nst.
Wallace Minn						aiden Surneme)	
Burial 2 Ceremation 3/Disemovel from Stete Mounth Hope Ceremberry February 12, 2000 Florence, Sc			_				(ip Code)
That Letter the disease, or complications that walked the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the disease, or complications that walked the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate the disease or conditions are conditions. In mediate Cause (Finel disease or conditions are conditions). Sequentially list conditions. If any, heading to immediate cause. Either Underlying Causes (Disease or injury resulting in death) Last Due to (or give consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): 24a. Wes an eutopsy performed? 24b. Were autopsy available prore of death of the cause are consequence of death of the cause are consequence of the cause of		1 ☐ Burial 2 ☐ Cremation 3 第 Bemovel from Stete	netory or other pl	L.			
23a. Part I. Enter the disease, or complications that required the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate and mode, or heart failure. List only one ceuse on each line. Approximate and line and the cause (Finel disease or conditions as a consequence of):		10000	Name and Addi Charles L. 1501 Fast.	ress of Facility Stevens Fu Fort, Avenue	neral Home,	Inc.	21230
Sequentially list conditions of the cause (Finel decease or conditions) Sequentially list conditions of the cause (Finel decease or conditions) Sequentially list conditions of the cause (Finel decease) Sequentially list conditions of the cause (Finel decease) Sequentially list conditions (Sequentially list conditions) Sequentially list conditions (Sequential	-	0.00				4	
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause 1 Yes 2 No 3 Probably 4 24a. Wes an eutopsy available prior completing of of death 1 Yes 2 No 1 If Yes 2 If Yes 2 No 1 If Yes 2 If Yes	ical Examiner	any, leading to immediate use. Enter Underlying use (Disease or Injury at initiated events		Jou	nds	1	
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural survestigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 28c. Describe how injury occurred work? 28c. Place of Injury. At home, ferm, street, factory, office 28c. Injury at Work? 28d. Describe how injury occurred wor		d.					
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death		It II. Other significant conditions contributing to death but not resulting in the un	derlying cause g	jiven in Part I.			to the cause of death?
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Thomicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Num 28d. Location (Street and Number or					24a. Wes an	eutopsy 24b.	Were autopsy lindings
25. Was case referred to medical examiner? 1					/		completion of cause of death
1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Fother (Specify) at Signature and title of outsiler 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Fother (Specify) at Signature and title of outsiler 28a. Date of Injury 28b. Time of Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28		Was once referred to medical		00.51			TUE TOS ZUINO
1 Natural 2 Accident 3 Suicide 4 Homicide Could not be determined See. Place of Injury - At home, ferm, street, factory, office		examiner? Hospital:	3 DOA	14.7			oily) at scene
3 Suicide 4 Prioriticide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)		1 Natural 5 Pending (Month, Day Year) Injury	. M 11	ury at ork?	28d. Describe how	v injury occurred	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 27 Medical Examiner: On the basis of summination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street building, etc. (Specify)		8	City or Town,	Stete)	ental Route Number,
29b. Signature and title of contribut 29c. License number 29d. Date signed (Month, Dey, Year)		(Check only 20 Medical Examiner: On the basis of examination and/or inv	occurred at the estigation, in my	time, date and place, opinion, death occur	and due to the ceu red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
February 07, 2000	Tall.		29c. Licer				
30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 2120				n Street			

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

be notified at once.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within EX hours after death. Page 6 may	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, in the funeral director, in the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must
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	1 - STATE REGISTRAR	STATE OF				OF HEAL		MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last,					<u> </u>		2. DATE OF DEATH			3. TIME OF DEATH	н
1	LOUIS ED	GAR	MERICA					February	DAY	YEAR	5:15 P	
- 8	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER 1	VEAR IF I	NDER 24 HRS.	7. DATE OF BIRTH	9,200		IPLACE (State or For	
	230-96-3499	1 X M 2 □ F		O YRS.	MONTHS	DAYS HOU	MIN,	April 17,	959	Count	X'	wgrr
~	9a. FACILITY NAME (If not inetitution, give	street and number)			96. CITY,	TOWN OR LO	CATION OF E	DEATH	9c. COU	NTY OF D	EATH	
DIRECTOR	Orchard Ridge Ro	oad			Han	cock			Wash:	ingt	on	
EC.	10a. STATE 10b. COUNT			10c. CIT	TY, TOWN OF	LOCATION					10d. INSIDE CITY	
E	PA Ful	ton			.,						LIMITS?	
	10e. STREET AND NUMBER	LON		W	arror	dsburg			T		1 YES 2 X	10
A		D 1				12.5					WHAT COUNTRY?	
FUNERAL	269 Pigeon Cove					172			US			
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDED FORCES? IF YES, GIVE	NT EVER IN U.S. AR	NO	14	AS DECENDE yes, specify (YES 2)	Cuban, Mexic	unic ORIGIN? (Specify ian, Puerto Rican, etc.) //y:	Yea or No—	14, RACI Black Speci		n,
	15. DECEDENT'S ED	I CATION									White	
COMPLETED	(Specify only highest grad	e completed)	(G	ive kind of	Work done du se retired.)	CUPATION ring most of w	vorking	16b. KIND OF I	BUSINESS/IND	USTRY		
اي	Elementary/Secondary (0-12)	College (1-4 or 5	+)									
<u> </u>	17. FATHER'S NAME (First, Middle, Last)		Tr	uck .	Drive			Constr		1		
BE CC	James Merica					18. 1		ame (First, Middle, Meld na Whinner	,			
9	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (Street and Nu	mber or Aurai	Route Number, City or 1	lown, State, Zip	Code)		
F	Goldie Lynn Meri	ca/Wife	2	69 P	igeon	Cove	Road	Warfordsb	urg, H	PA 1	17267	
	20s. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Ref 4 Donation 6 Other (Specify)	noval from State	20b. PLACE	AND DATE	OF DISPOSIT	ION (Name of			LOCATION -	City or To	own, State	
	21. SIGNATURE OF FUNERAL SERVICE	NEMSEE	2					Home, P.		-, 11		
	Kich	a/U	whe		14	W.M	in St	.Hancock.	MD 217	750-0	1368	
	23. PART i. Enter the diseases, or shock, or heart fellure	complications the List only one ce	at caused the de use on each line	eth. Do	not enter t	he mode of	dying, au	ch as cardiac or re-	spiratory arr	est,	Approximation Interval Be	tweer
	iMMEDIATE CAUSE (Final disease or condition										Onset and	
	resulting in death)		Mulitipl								moment	S
		DOE IC	(OR AS A CONSE	OUENCE O	(*) :							
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. DUE TO	OR AS A CONSE	QUENCE O	F):							
5	CAUSE (Disease or injury	C	100 10 1001									
Ē	that initiated events reaulting in death) LAST	DOE IC	(OR AS A CONSE	DUENCE O	+):						ì	
ш		d										
CC	PART II. Other significant condition	ns contributing to	death but not r	resulting	In the und	eriving cau	se given ir	Part I. 24a. WAS	AN AUTOPSY	24h	. WERE AUTOPSY FIN	DINGS
8				•		,	9	PERF	ORMED?	1	AMAILABLE PRIOR TO COMPLETION OF CA	0
								1 YES	2 NO		OF DEATH?	₩0€
Σ	DID TODA COO LICE CO.										1 YES 2 NO	0
Ä	DID TOBACCO USE CONT	RIBUTE TO CA					NCERTA	N 🗆				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TH (Check on	ly one)						
PHYSICIAN: MEDICAL	1 ¥YES 2 □ NO		ER/Outpatlant 3	□ DOA	OTHER:	g Home 5	Rasidence	6 St Other (Specify)	Roady	vav		
F	27. MANNER OF DEATH	26a. DATE Of (Month, I	F INJURY Day, Year)	28b. TIM		Sc. INJURY A WORK?		28d. DESCRIBE HOY		_		

1 Dinpetient 2 ER/Outpetient 3 DOA 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY D

28c. INJURY AT WORK?
1 YES 2 February 9, 2000 3:00 MF 1 U 7
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 2 NO S Cother (Specify) Roadway
28d. DESCRIBE HOW INJURY OCCURED vehiclerear ended well drilling

28f. LOCATION (Street and Number or Rural Route Number City or Town, State)

Orchard Ridge Rd Hancock, MD

1 CEHTIFYING PHYSICIAN	in the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and manner	r as stated.
2 MEDICAL EXAMINER: OF	he basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and d	us to the c

(Check only one) 296. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER

lw. Ditto it as

Investigation

6 Could not be datarmined

DO1062

29d, DATE SIGNED (Month, Day, Year) February 10,2000

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 21740

31. DATE FILED (Month, Day, Year) **FFB17** 2000

1 Natural

2 Accident
3 Suicide

4 Homicide

29a. CERTIFIER

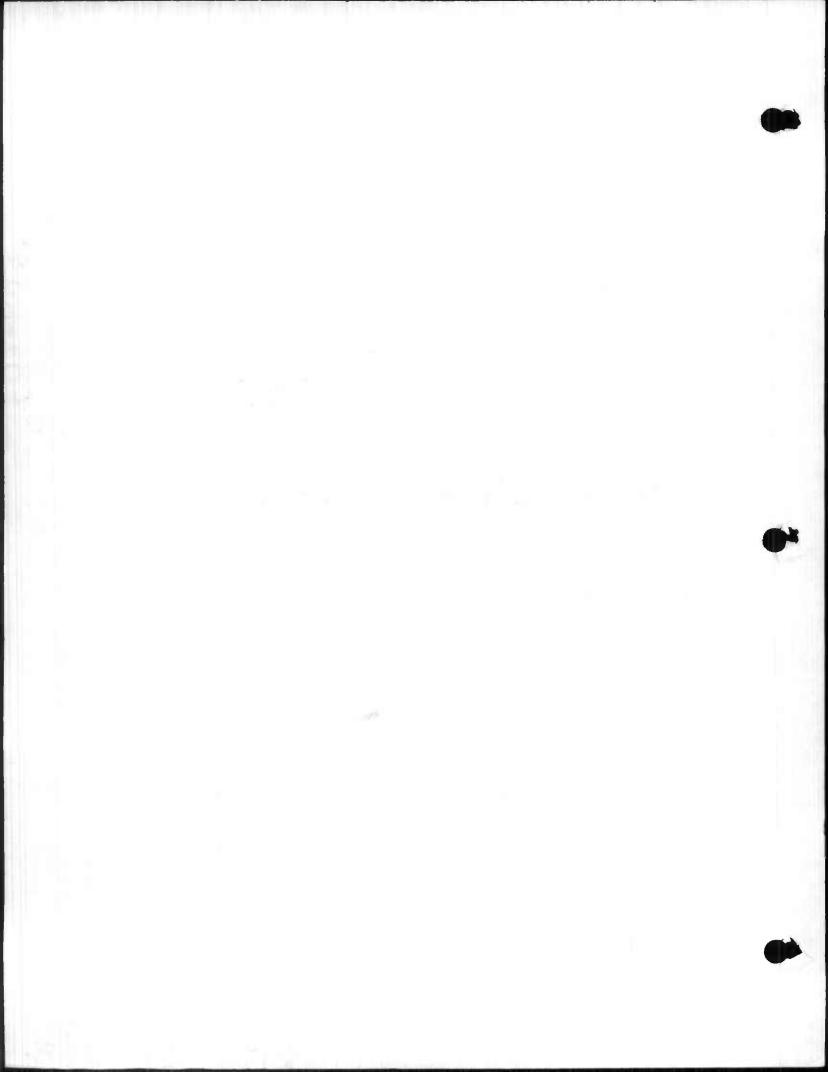
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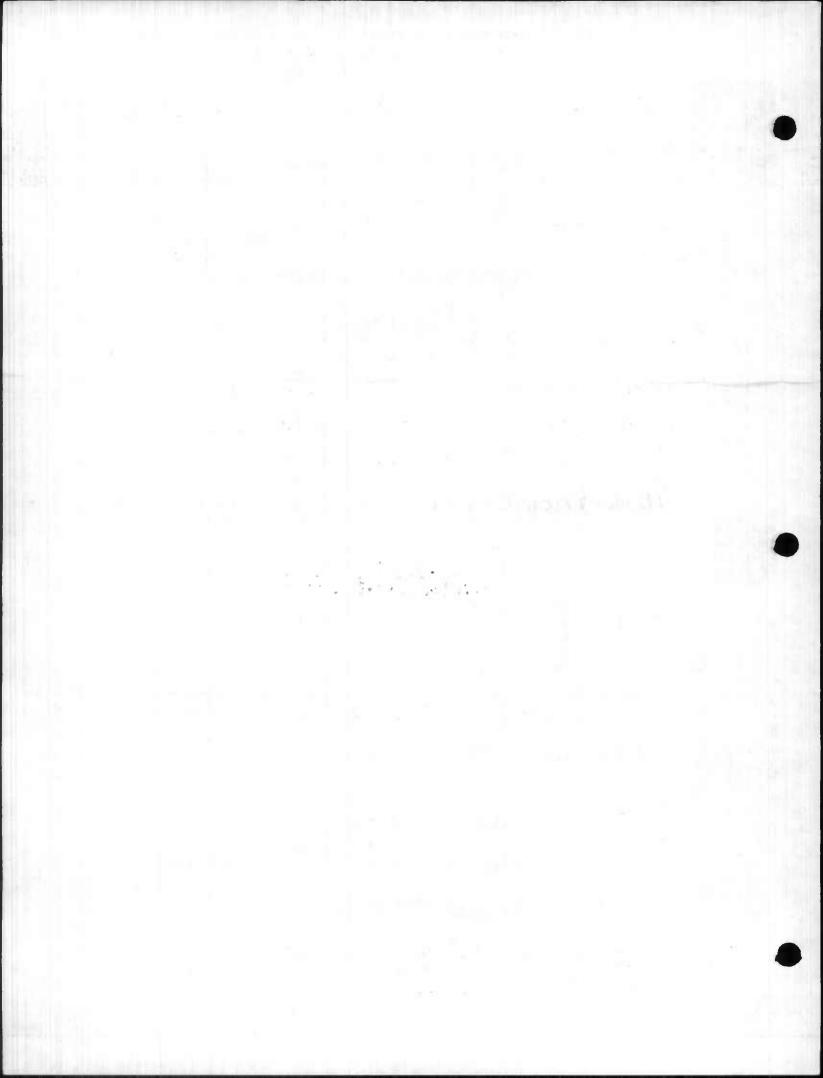
32. REGISTRAR'S SIGNATURE





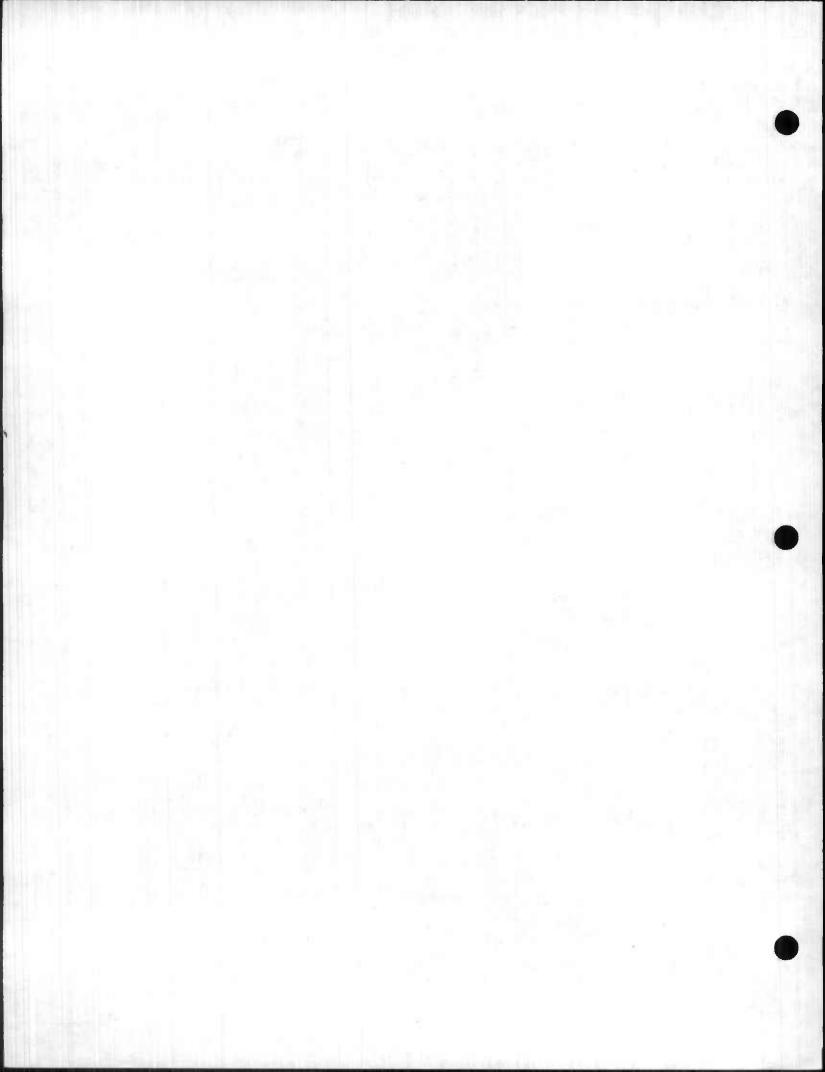
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 4 9 2 9 State of Maryland / Department of Health and Mental Hygiene

				Cert	ificate of	Death	· ·	Reg. No.		
hysicia /Medic	al	Decedent's Neme (First, Middle, Last,	CHARLA street and number)	-5	MILLE	4b. City, Town, or I	2. Dete of Der Month O 2 ocation of Deeth	Dey 13	POOD	3. Time of Death 7.54
xamino neral ector	er	Good Samaritan Ho 5. Social Security Number 6. Sec. 1217 06 9160	spital	. last birthday) Yrs.		Baltimore If Under 24 Hrs. Hours Min.	8. Dete of Birt	Balti	nore C	ity e (State or Foreign re City, Mi
anow id at		Usuel Rasidence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or Loca	ation				10d.	. Inside City Limits
notified at	Directo	Maryland Baltimore 10e. Street and Number	Ba	ltimore	City 10f. Zip Code			10g. Citizen of V	Mhot Country	1 Yes 2 No
5 25		4011 Overlea Avenue			21206			USA	viiot Country	
Examiner to	by Funeral	11. Meritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	I2. Was Decedent Ever in t Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: WW	1f ` 1 [es Decedent of Here, specify Cub	dispanic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No- Pican, etc.)		e - American k, White, etc	
the Medical Ex	Completed	15. Decedent's Edu (Specify only highest grede Elementery/Secondery (0-12)	cation	16e. Decede (Give ki life. Do	nt's Usuel Occup ind of work done O NOT use ratire	petion during most of wor d)	king	16b. Kind of Bu		
19.44	To Be C	17. Fathar'a Name (First, Middla, Last) Abtil Miller			oo operati	18. Mother's Nen Bertha Br				
	-	19e. Informent's Name/Relationship (Ty	pe, Print)	_		and Number or Ru	ral Routa Numbe			oda)
other tr		Verna M Miller (Wife) 20a. Method of Disposition	20b.	4011 Ov Plece of Disposi		nue Baltimo	re, Maryla	and 21206 20c. Location -		Stete
ary or		1 ☑ Burlal 2 ☐ Crametion 3 ☐ R 4 ☐ Donetion 5 ☐ Othar (Specify)	emovel from State	kwood Cen	itory or other pla	uary 17, 20		Baltimore		
any inju	ľ	21. Signature of Funeral Service License	ob Char	. I		oss of Fecility neral Home r Road Balt	imoro Mor	rail and 21	236	
the bu	n/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence or a consequen	ence of):				Č	2 Welks
p d f	Physician/M	Pert II. Other algalificant conditions con	tributing to death but not res	sulting in the und	eriying cause giv	van In Part f.	23b. Dfd t	obacco uae co	ntribute to th	ne cause of death?
0	by Ph	ALZHEI	MER'S	DEM	ENT	A	101	res 2 No	3 Probat	oly 4 Junknown
2 should be	Completed						24e. Wea	en eutopay rmed?	eveile	eutopsy findinga able prior to eletion of cause eth?
rector, page 2		25. Was case referred to medical					1 🗆 Y		1 🗆 Y	es 25 No
0	ToB	examiner?	ospital: 1 Inpatient 2 28e. Data of Injury (Month, Day Year)	ER/Outpetient 28b. Tima of Injury	3 DOA Oth	4 LI Nuising H	th (Check only o ome 5 Resid 28d. Dascribe h	lenca 6 00th		
In by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - At h	ome, farm, straa	M 1□	Yes 2 □ No	28f. Location (S City or Tow	Straet and Numb n, State)	er or Rural R	loute Number,
stoly fill	edical C	29a. Certifier (Check only ane)	clan: To the best of my knoer: On the basis of examination and menner stated.	owledga, death o ation end/or inve	occurred et tha tir stigation, in my o	na, data end placa pinion, deeth occu	and dua to tha d red at the time, d	causa(s) and ma date end place,	inner aa state and due to th	ed. a ceuse(s)
dwoo	_	29b. Signature and title of certifier	A STORES		29c. Licens	e number		29d. Dete signe	d (Month, De	y, Year)
/		1//22	gu 54/1	m	D	4547	2/,	2-1	3.6	n 4030
	- 1	30. Name and addrass of person who co	polated cause of death (the	n 23a) /Tuna De	Sam & L				*	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 1, 930

				0.0		iai y iai i		tificate of	Health and Death		Reg. No.		
Physician /Medica	1	Decedent's Ner	ne (First, Mide BELL)	10.				MARST	ON	2. Dete of De Month FEBRUA		20්රීර්	3. Time of Death 10:12PM
Examine	4.0			on, give street (HEALTH					4b. City, Town, or BALTIMO			anty of Death ALTIMO) F
Funeral Director		Social Security 214-01-	Number	6. Sex	7. 4	ige (In yrs. li 95		If Under 1 Year Months Deys	If Under 24 Hrs	8. Dete of Bi	rth	7	place (State or Foreign
		ual Residence	1			10- 03-	*						0.11-11-0.11-1-1
death with the Manyland ms 23e or 28e-f show Lmast be notified at		a. Stete MD	BALTII				Town or Lo	cation					1 ☐ Yes 2 ☑ No
the M	10	e. Street and N		IONE		2000		10f. Zip Code			10g. Citizen	of What Cour	ntry?
th with	7:	25 MT.W	ILSON I	LANE AP	T. 41	9		21208				USA	
5 22	11 Ac	Meritel Status 1 Never Mer Widowed		orried 1	ned Forces Yes 2X Yes, Give er or Detes] No	1	Wes Decedent of I f Yes, specify Cub I ☐ Yes 2 ☐ No	Hispanic Origin? (ben, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		Race - Americ Bleck, White, ecity WHIT	etc.
72 hours	Complete	(Spe		nt's Educellon est grade comp	oleted)		(Give	dent's Usuel Occu kind of work done	during most of we	orking	16b. Kind o	d Business/In	dustry
21215- d within 72 plene. r than 'nai		Elementery/Sec	condary (0-12)	Co	llege (1-4o	5+)		DO NOT use retire KKEEPER	od)		DEPT.	STORE	
and 2 be filed at other event, in	D 17	Felher's Neme	(First, Middle	, Last)						me (First, Middle			
laryland 2 2 should be filed and Mental Hygi a marked other aumatic event,	2 14	ORRIS				IERSON			LEAH			YERHOF	
y, Maryland 21215-0020 and 2 should be filed within 72 hours at alth and Mental Hyglene. 27 is marked other than "natural", or or traumatic event, the Medical Enter		e. Informent's I		iship <i>(Type, Pri</i> IECE	int)				t and Number or R E CIRCLE				
Baltimore, M permit. Pages 1 and 2 Department of Health a important: If Nem 27 is any Injury or other tra page.	20	e. Method of Di 1 XBurial 2 4 Donation	Cremetion	3 □Remove	el from Stet	e Ce	FRIEN	sition (Name of DSHIP her pla METERY	ace)	Dete 2/16/200		on - City or To	
Balting pemit. Pe Department Importants any injury page.	21	. Signeture of F	unerel Service	Licensee (the	7		Neme end Address	ess of Fecility TERSTOWN	SOL LEVI			
-	23	a. Pert1. Enter shock, or he	the diseese, dent feiture. Lis	or complication st only one cau	s that causes se on each	ed the deeth line.	. Do not ent	er the mode of dy	ing, such es cardie	oc or respiratory	errest,		Approximate Intervel Between Onset end Death
Physician / /Medical /	lm	mediete Cause	(Finat			Stro							i week
Examiner	Le	sease or condit sulting in deeth		θ			es e consec	quenca ot):					
D 25 0				b		Hyre	sper.	5120					20 years
60, be executed ician and buriel-transit	Se	equentielly list of	onditions, immediete			Due to (or	es e consec	juence ot):					
8760, sate be experient the burish	G Ca	any, leading to use. Enter Und use (Disease de la initieted even sulting in deeth)	or Injury	c		Due to (or	es e conseq	uence of):					1177
0 = = 0	5	sutting in Geetin,	Last										
D the stop	5			- 0	_								
O the state of	Pe	rt It. Other sign	ificant condit	lons contributir	ng to death	but not resu	iting in the u	nderlying cause gi	iven in Pert I.		Yes 2		o the cause of death?
S, P.	-												
The law requires that The law requires that Sate has been signed to page 2 should be determined by										24e. Wei	s en autopsy ormed?	CC	fere eutopsy findings vailable prior to empletion of cause deeth?
The law ate has page 2	5									1 🗆	Yes 2KN	lo 1	☐ Yes 2☐ No
Vital I	25	Was case refe exeminer?	erred to medic		di .			100		eeth (Check only	one)		
A Sign H		1 ☐ Yes 2	No	Hospite 28e	1 🔲 Inpa		ER/Outpatier 28b. Time of	II SLI DOM		Home 5 ☐ Res			ty)
After fune		1 Neturel 2 Accident	5 Pend	ing tigetion	. Dete of In (Month, E	ey Year)	Injury	Wo	ork?]Yes 2□No				
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Divisic To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the		e. Certifier (Check and		i Examiner: Or		of examineti			ime, date end ptec opinion, deeth occ				
To the within To the complete		b. Signature an	d table of certif	ier	M	n			se number	+5	29d. Dete s	igned (Month,	Day, Year)
Mos	30	Name and add	A 1	n who complete	ed cause of	death (ttem	23a) (Type,				3.lhr	ore N	10 21202
State	31	Date filed (Mo	nth, Day, Yea	r)	32. Regis	trer's Signet	ure	a	1				
Registra		E	ED 1 17	2000	France	war	19	kom M.	1				



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible 14 9 State of Maryland / Department of Health and Mental Hygiene

sician	1. Decedent's Name (Firs	st, Middle, Last)				Death	2. Date of D		Va	3. Time of Death
edical	Andrew				more		_			2000	12:43 M
miner	4a Facility Nama (If not in	1 -	11 1		1.0 -:+	. 1	by City, Town, or		th 4c. County	of Death	
		onns 6. Sa		Aga (In yrs. la	765P11	er 1 Year	If Under 24 Hrs	nore 8. Data of Bi	india	O Distri	Inna (Carta de Francis)
ral tor	5. Social Security Numbe 216-52-4742 Usual Residence of Dece	2 1/1	M 20 F	50	Yrs. Month		Hours Min.		1949	BALT	lece (State or Foreign try) IMORE, MD
ral Director		County		10c. City,	Town or Location					1	0d. Inside Clty Limits
tor	MARYLAND				BALTIMORE						1√ Yes 2□No
Directo	10e. Street and Number				10f. 2	ip Code			10g. Citizen of V	Vhat Coun	itry?
ale	878 W. LO	OMBARD	STREET			21201	1	117	USA		
Funeral	11. Marital Status		12. Was Decede	nt Ever in U,S	. 13. Was Dec	edent of H	ispanic Origin? (S an, Mexican, Puer	specify Yes or N to Rican, etc.)	o- 14. Raci	e - Americ	
by	1 ☐ Nevar Married 2 3 ☐ Widowed 4 ☐ D		1 Yas 21 If Yes, Give Year or Date	Σχνο \$:		2% No	Specify:		Specify		O AMERICAN
pote	15. D	Decedent's Edu	ication		16a. Decedent's Us (Giva kind of v life. DO NOT	ual Occup	ation during most of wo	rkina	16b. Kind of Bu	usiness/Ind	dustry
Completed	Elementary/Secondary	, ,	College (1-4	or 5+)	BRICK				BRICK	YARD	
Be C	17. Father's Name (First,	Middle, Last)						me (First, Middle	e, Maiden Sumam		
To B	ANDREW	W. M	URDOCK S	SR.			RACHEI	BRAN	NDFORD		
-	19a. informant's Name/R				19b. Meiling Addre	ss (Street	and Number or R	ural Route Numi	ber, City or Town,	State, Zip	Code)
	RACHEL N	MURDOCK			878 W. L	OMBAF	RD STREE	r, BALTI	MORE, MA	RYLA	ND 21201
	20a. Method of Disposition 1 🕅 Burial 2 □ Cre.		Damouel from Cta	Cer	ce of Disposition (N	lame of rother place	ce)	Dete	20c. Location -	City or To	wn, State
	4 Donation 5 0			MT.	ZION CE	METER	RY.	2/18/00	LANSDRO	WN,	MD.
	21. Signature of Funeral	Service Licens	00		FSTEP	and Addre	S. OF FUNERA	N SFR.	РΔ	7575	
4	They	-U h	2. Oste	7			PLACE,				
	23a. Part1. Enter the disc shock, or heart Milu	ease, or compl	ications that cau	ad the death.						1	Approximate Interval Between
											Onsat and Death
	Immediate Cause (Final disease or condition resulting in death)	1	s. 5.	osis.							10 Days
-	resulting in obalin)			Due to (or	as a consequence o	1):					
nlne			b. Po	n coliti	5					1	10 Days
Examiner	Sequentially list condition if eny, leeding to immedia cause. Enter Underlying Ceuse (Disease or injury	ns, ate		Due to (or	as a consequence o	f):					
edical	Ceuse (Disease or injury that initiated events	~	c	Due to for	is a consequence of	1).					
=				D00 10 (01 1	is a consequence of						
	resulting in death) Last		d								
-	resulting in death) Last									j	
-	resulting in death) Last Part II. Other significant		ntributing to deat	n but not result	ing in the undartying	causa giv	an in Part I.	23b. Die	d tobacco uas co	ntributs to	the cause of death'
-	Part II. Other significant	conditions cor	ntributing to deat	n but not result	ing in the undartying	j causa giv	ran in Part I.		d tobacco uas co		
by Physician/M	Part II. Other significant	conditions cor	ntributing to deat	n but not resul	ing in the undarlying	j causa giv	an in Part I.				
by Physician/M	Part II. Other significant	conditions cor	ntributing to deat	n but not resul	ing in the underlying	j causa giv	ran in Part I.	1 C		3☐ Pro	bably 4 Unknow era autopsy findings ailable prior to
by Physician/M	Part II. Other algorificant of Circhosi	conditions con			ing in the underlying	j causa giv	ran in Part I.	1 C	Yes 2XNo	3 Pro	bably 4 Unknow
by Physician/M	Part II. Other algorificant of Circhosi	conditions con			ing in the underlying	g causa giv	ran in Part I.	24a. Wa	Yes 2XNo	3 Pro	bably 4 Unknow era autopsy tindings ailable prior to mplation of causa
Be Completed by Physician/M	Part II. Other significant	conditions con	faciline		ing in the underlying		26. Place of De	24a. Wa	s an autopsy formed?	3 Pro	era autopsy findings ailable prior to . mplation of causa death?
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDEO ITEM #25 PER WERBAL RESP. G780 2/17/2000 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month 3. Tima of Death **Physician** Baby Boy Monroe 2000 2 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARYLAND Baltmore If Under 24 Hrs. 8, D If Under 1 Year 8. Dete of Birth (Month, Day, Year) 2/6/2000 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 220-90-4653 1 M 2 F Yrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f short Baltimore 18 Yes 2 □ No mD N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 706 North vondale 21222 U.S.A. Herne 23a Funeral Wes Decedent Ever in U,S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Detes: 14. Rece - American Indien, Bleck, Whita, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Never Married 2 Merried natural, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h. Kind of Buainess/Industry flied within Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Infant N/A N/A permit. Pages 1 and 2 should be file postulated by the page of the 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 Honroe 20 Troyiano Monroe Sr nna 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Troyiano/Trina Monroe/Parents 706 N.Avondale Rd.Balto.Md.21222 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stefe Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) King Memorial Park 2-10-00 Randallstown, Md. 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Lewis T.Gwynn Funeral Home 4517 Parkheights Ave.Balto.Md.21215-6393 Lewis T. Gwynn Lwynn Pert Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on sach line. Approximate intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 0 Examiner 0 Examiner certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): P 2 signed by the þ Completed

certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certification of the funeral director, it is the funeral director. 8 Medical Certification: To

29b. Signeture and line of gentline

31. Date filed (Month, Dey, Year)

-0

Part II. Other algnificant conditions co	ontributing to death but not res	sulting in the underlying	g cause given in Pert I.	23b. Did tobacco use co	entribute to the cause of death?	
				1 □ Yee 2 □ No	3 Probably A Unknown	
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?	
25. Was case referred to medical exeminer? 1 □ Yes 2♥ No	26. Place of Deeth (Check only one)					
	Hospitel: A Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Menner of Death 1	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occur	3d. Describe how Injury occurred	
	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			281. Location (Street and Number or Rural Route Number, City or Town, Stete)		

29c. License number

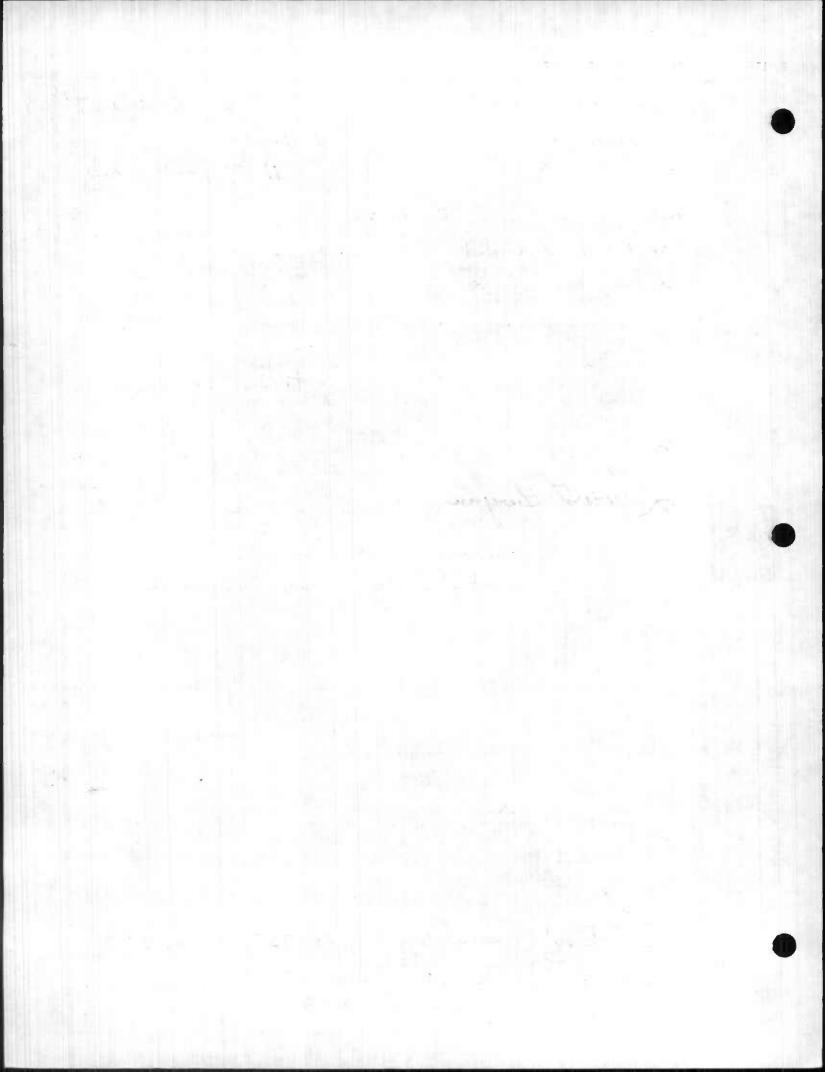
29d. Dete signed (Month, Day, Year)

State Registrar ompleted cause of death (Item 23a) (Type, Print)

2

32. Registger's Signature

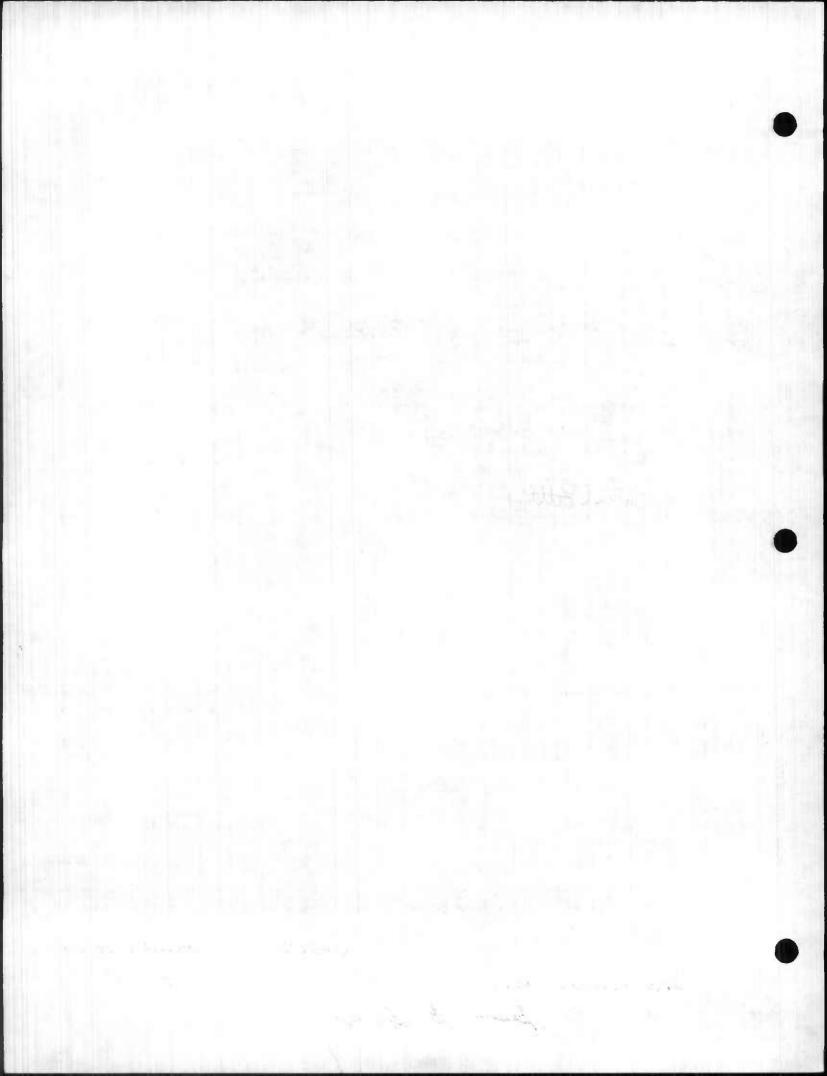
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State of Maryland / Department of Health and Mental Hygiene 0 4933

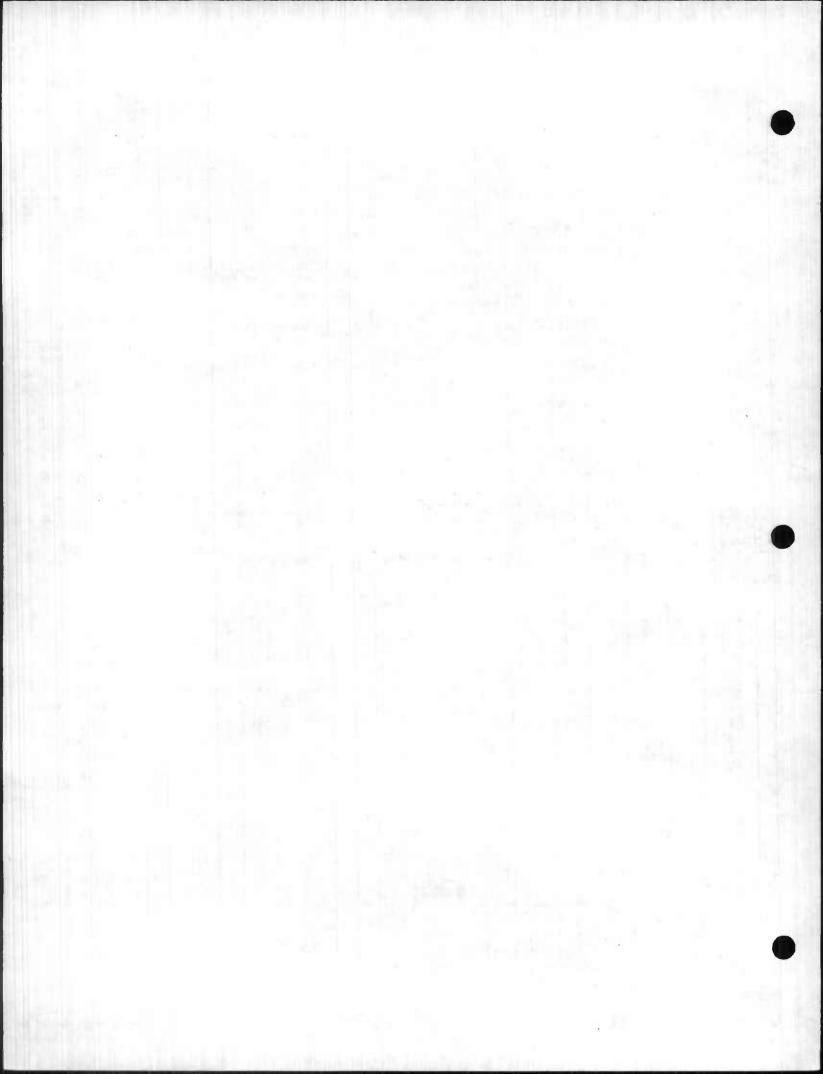
_				Ceru	ficate of	Death		Reg. I	No.					
	1. Decedent'a Name (First, Middla, I	Last)						2. Date of Death Month Day Year 3. Time of						
an I	Lillian Ann Mac	auley				Februa				Year 000	6:00 A			
al . er	4a Facility Nama (If not institution, give street and number) 4b. City, Ti						vn, or Location		4c. County o		0.00 11			
	Stella Maris Timoniu								Balti	more				
	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 H							of Birth onth, Day, Yes 2 15 1		9. Birthpl Count	rthplace (Stete or Foreig country) 'y Land			
t	Usual Residence of Decedent								210 1	act y 1	una			
	10e. State 10b. County		10c. City, To	own or Loca	tion					10	d. tnside City Lim			
	Maryland Baltimo					1 ☐ Yes 2 📉								
Completed by Funeral Di														
	11. Marital Status 1 Never Married 2 Merried	Armed Forces 1 □ Yas 2 ☒	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Specify Cuban, Mexicar If Yas, specify:			an, Mexican	in? (Specify Ya , Puerto Rican,	s or No-	14. Race	14. Race - American Indian, Bleck, White, etc.				
	3 Widowed 4 □ Divorced	Year or Detes:				ороску.			Specify.	W	hite			
	15. Decedent'a (Specify only highest of		-10	6a. Deceder (Give kir	nt's Uaual Occup ad of work done	ation during most	of working	16b	. Kind of Bus	iness/Ind	ustry			
	Elementary/Secondary (0-12)	College (1-4or			(Give kind of work done duri life. DO NOT use retired)									
	8			Homema	aker	40.00			vn Hom					
	17. Father's Name (First, Middle, La.						8. Mother's Neme (First, Middle							
	John T. K	earney				Cath	erine		Sch	nelly	7			
	19a. Informent's Name/Relationship	(Type, Print)	1	19b. Meiling	Address (Street	end Numbe	r or Rural Route	Number, Cit	y or Town, S	Stete, Zip	Code)			
	Sr. Anne Hefner	(n	iece)	11 Pe	roba Co	urt E	Baltimor	e, Mar	ryland	212	34			
1	20a. Method of Disposition 1 ⊠ Buriat 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control Contr		ceme	etery, creme	ion (Neme of tory or other ple Cemetery		2-14-		Location - C		Maryland			
	21. Sometime Funerel Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc.									Inc.				
	6500 York Road Baltimore, Maryland 21212										1212			
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.													
	Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (or as	e conseque	nce of):									
Physician	art If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.													
	Part II. Other significant conditions	contributing to death I	but not resulting	g in the und	erlying cause giv	ven in Pert I.	23	b. Did tobec	co use conf	tribute to	the cause of dea			
	Part II. Other significant conditions	contributing to death I	but not resulting	g in the und	erlying cause giv	ven in Pert I.	23				the cause of dec			
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6	Part II. Other algnificant conditions	contributing to death I	out not resultin	g in the und	erlying cause gh	ven in Pert I.		1 ☐ Yes	2□ No	24b. We ave cor	re autopsy finding illable prior to impletion of cause			
on belong the	Part II. Other algnificant conditions 25. Was case referred to medicat	contributing to death I	out not resultin	g in the und	erlying cause gh		24	a. Was an au performed	2□ No	24b. We ave cor	ore autopsy finding illable prior to inpletion of cause death?			
to personal to the second	25. Was case referred to medicat examiner?	Mosnital:			Loui	26. Place	of Deeth (Chec	a. Was an at performed 1 Yea k only one)	2□ No tropsy 7	24b. We ave cor of 0	re autopsy finding illabe prior to inpletion of cause leath?			
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		State of Mary		artment of rtificate o		nd Men		iene	UH	934	
	1. Decedent's Name (First, Middle, Last)						Date of Deat Month		Year	3. Time of Death	
Physician /Medical	NORBERT A. NE	WELL					BRUARY			22:24 P.M.	
Examiner	48 Facility Neme (If not institution, give ST. MARY S HOSPI	,		4b. City, Tow LEONA	m, or Location		4c. County of Death ST. MARY S		7 S		
Funeral Director	217 22 7700	7. Age (Ir	yrs. last birthday) 2 Yrs.	If Under 1 Ye Months Day		Min.	Date of Birth Month, Day, 6-06-1	9. Bir 1927		irthplace (State or Foreign Country) MARYLAND	
9 8	Usual Residence of Decedent 10a. State 10b. County	cation					10	Od. Inside City Limits			
The Maryle 28s-f sho notified at rector	MD			BALTIM	ORE		1 X) Yas				
E 52 G	10a. Street and Number 507 S. LONGWOOD	STREET		10f. Zip Code	21223		10g. Citizen of What Country? U.S.A.				
ours after death viril, or lisms 234 Examiner must 1 by Funeral	11. Merital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yea, Give Year or Dates:		Was Decedent of Yes, specify C		in? (Specify Puerto Rica	Yes or No- in, etc.)		ce - Americ ck, White, o		
ad within 72 hours all systems. ser than "natural", or it, the Medical Exam Completed by F	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	tent's Usual Occ kind of work doi DO NOT use ret FEUR	ne during most	of working		RANSPO		Industry ION INDUSTR	
Mental Hyg Mental Hyg arked other afic event, I	17. Father's Name (First, Middle, Last) LEO NEWELL					18. Mother's Name (First, Middle, EDNA E. BOSI			the second secon		
nd 2 sho sith and h 27 is me r traums	19a. Informant's Name/Relationship (7 MARGARET J. NEWEL)		7				ral Route Number, City or Town, State, Zip Code) , BALTIMORE, MARYLAND 21223				
emil. Pages 1 ar Nepartment of Hear reportant: if Hem 2 my injury or other stide.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removal from State	Ob. Plece of Dispo	sition (Name of natory or other p	place)	02-	eate 2	20c. Location - City or Town, State BALTIMORE, MARYLAND			
permit. P Departme Importan any injur	21. Signature of Fundad Service Licen		1	Name and Add			TNC	4107 W	ILKEN	S AVENUE MD 21229	
ndificate be executed ng physician and a se the bunst-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	b	to (or as a consequence to (or a))).	uence of): uence of):					1		
requires that the death certificat been signed by the attending phy hould be detached for use as th eted by Physician/Medi	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause	given in Pert I.					the cause of death?	
to law requires that the death is has been signed by the atte tge 2 should be deteched for impleted by Physicia	COPD	, LVA					24a. Wes ar	autopsy		ere autopsy findings	
D 2 st						_	perform	1/	of e	mitable prior to impletion of cause death?	
F # 8 0	25. Was case referred to medical				26 Place	of Death (C)	1 ☐ Ye		11	Yes 20 No	
Physician: this certificant director,	avaminar?	Hospital:	2 ER/Outpatien	1 30 DOA	Other			nce 8 🗆 Oth	ner (Specifi	y)	
4 5 7	27. Manner of Death 1 Natural 5 Panding 2 Accident Investigation	28e. Date of Injury (Month, Day Ye	-	28c. Ir	28c. Injury at Work? 28d. Describ			ibe how injury occurred			
tal or Attanding P irs after death. el Director: After t led in by the funer: Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, str	eet, factory, offic	20		Location (Str		ber or Rura	il Route Number,	
To the Hospital or within 24 hours afte to the Funeral Diricompletely filled in Medical Cert		sician: To the best of my iner: On the basis of exa and manner stated.									
Within To the Com	29b. Signature and title of cooffier	42m			29c. License number			29d. Date signed (Month, Day, Year) 2 - 15 - 80			
8x	30. Name and address of person who o				UT RD.,	LEONA	ARDTOW		2065		
State Registrar	31. Date filed (Month, Day, Year) FFR 1 7 200	32. Begistrar's	Signature &.	Spore	and a						

DHMH 16 Rev 6/1

NORBERT, NEWELL A.



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Year **Physician** Margaret Ann Puller Feb. 16, 2000 4:00 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 809 S. Ponca St. Baltimore If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Deys 1 □ M 2 🔀 F Director 214-20-4658 Jan.6,1926 Md. Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. N/A Baltimore XXYes 2 No Director 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be n 809 S. Ponca St. 21224 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Stetus Pages 1 and 2 should be fled within 72 hours after instit of Health and Mental Hygiene.

Intel if them 27 is marked other than "natural", or itse ury or other trainmatic event, the Medical Examine 1 Yes XXNo
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ SpecifyWhite 3€Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) 10 yrs. Nurse Aid Hospital 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 88 George Stancil Edna Brown 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lee Puller son 809 S. Ponca St. Baltimore Md. 21224 20b. Plece of Disposition (Nama of cemetary, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State F28006 Department of Important: If any injury or BBSs. Baltimore 4 ☐ Donetion 5 ☐ Other (Specify) 25 Signature of Fungral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part. Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Deeth **Physician** /Medical Immediata Cause (Finel disease or condition resulting in death) hetadolic Bladder Care Examiner Examiner or Attending Physician: The law requires that the death certificate be executed and Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): 080 P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 PUnknown Division of Vital Records, Completed by 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? certificate 1 Yes 28 No 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was case rafarred to medical axaminer? 28. Piace of Death (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes ₽ No this 28a. Deta of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 1@Neturel 5 Pending 1 Yas 2 No To the Hospital or Attendition within 24 hours after death. To the Funeral Director: A Investigation 2 Accident the 6 Could not be datarmined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homlcide 29e. Certiflas 16 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, end due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and pleca, and dua to the ceuse(s) end menner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

31. Data filed (Month, Day, Year) FEB 1 7 2000

MILHARL

PURTELI

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

32. Registrar's Signeture

JHSUMC

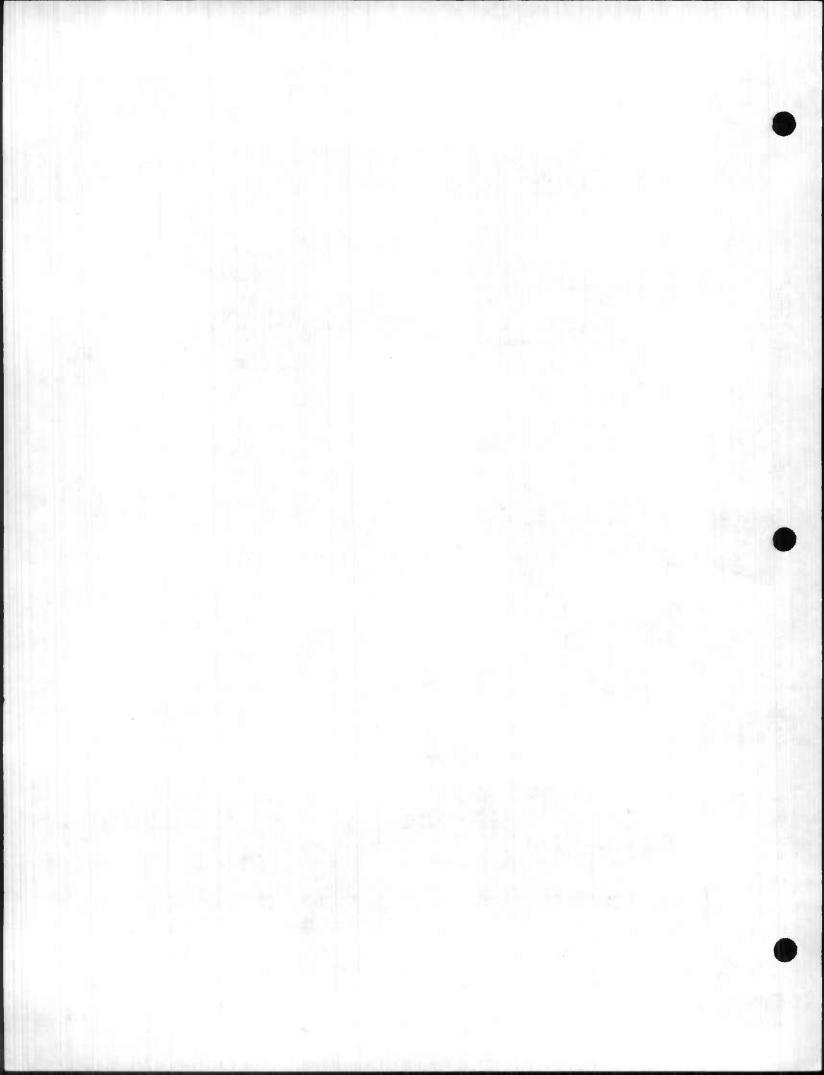
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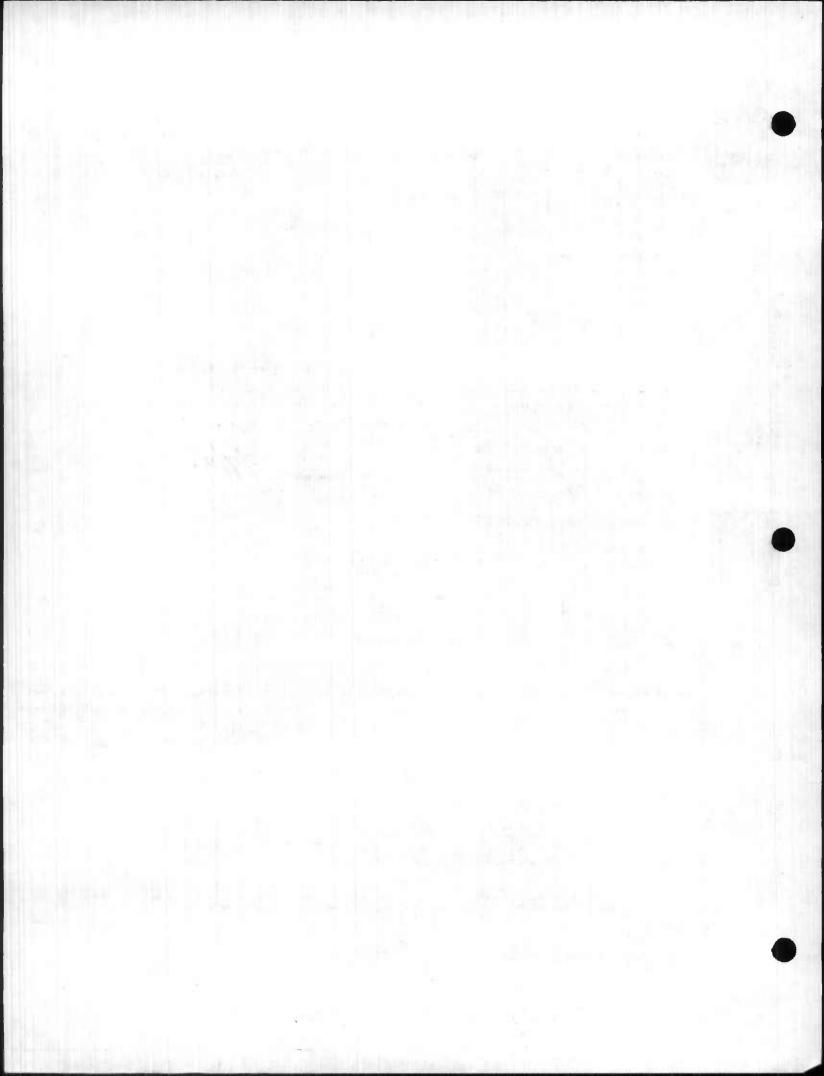
Ave BALTIMOR Md 21224

4940



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 4936

08	92-033	State of Maryland / Departme	ent of Health ate of Death							
	Physicia	Decedent's Name (First, Middla, Last)	2. Date of Month) Day	Year	3. Time of Death				
뭑	/Medica	William G. Pero, Jr.	own, or Location of 0		3, 2000 County of Death	1620 PM				
	Examine	405 DOMER COURT	LAUF			PRINCE GEORGES				
	Funeral Director	215-72-1724 1X) M 2 F 43 Yrs. Month		Min. 8. Data of (Month) Apr.	of Birth h, Day, Year) 29, 1	9. Birthp Cour 956 Penn	place (State or Foreign htty) 1Sylvania			
	pur *	Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location				1	Od. Inside City Limits			
	Maryle 4 sho				t Ki Yes 2 □ No					
h the	r 28a		Zip Code		10g. Citiz	en of What Cour	ntry?			
	th with		20707			USA				
020 urs after dee	72 hours after deeth with the Maryland natural, or ttems 23a or 28a-f ahow deal Examine must be notified at	I 1 Nevar Married 2 Married 1 Yes 2 No	pedent of Hispanic Or pecify Cuban, Mexica 2 X No Specify			14. Race - American Indian, Black, Whita, etc. Specify: White				
2-0	72 hor	15. Decedant's Education 16a. Decedant's U.	sual Occupation	net of working	16b. Kin	nd of Business/Inc	dustry			
21	ithin 7	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 4 Analyst	work done during moduse retired)	ISI DI WORKING						
Baltimore, Maryland 21215-0020 pemit. Pages I and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mentel Hygiens. Important: If I fem 27 is marked other than "natural", or itsma 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examinar must be notified at once.	Hor the	12 4 Analyst		nar'e Nama /Firet Mi			of Defense			
	William G. Pero, Sr.		nna Walker	Nama (First, Middle, Maiden Sumama)						
	shoul meri meri		ess (Street and Numb			Town, State, Zip	Code)			
	and 2 eith a 27 is pr tre	Beth Robinson/Friend 1021 8th	Street	Laurel, M	aurel, Maryland 20707					
	of He f Nem	20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from Stata	lame of r other place)	Date	Date 20c. Location - City or Town, Sta					
	ment ment: hant: h	4 Donation 5 Other (Specify) Balt. Wash. (Laur	el, Mary	ryland			
Bal	Balt permit. Departi Importa any Inju	21. Signature of unergo enfoyes Licensee 22. Nama Flect	Home, Inc							
_	40349	7601	Sandy Spr	ing Road	Laur	el, Mary	land 20707			
x 68760,	© € G	Immediate Causa (Final disaasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediate causa. Entar Undertying Causa (Disaase or injury that initiated evants rasulting in death) Last Last Causa (Disaase or injury that initiated evants rasulting in death) Last	n):	of Head	7					
Box	attend for us	V.								
P.O.	as that the death certific igned by the attending p be detached for use as	Part II. Other algnificant conditions contributing to death but not resulting in the underlying Diabetes mellitus	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Records,	The lew requires trate has been signe page 2 should be d				Was an autop performed?	CO	ere autopsy findings ailable prior to impletion of cause death?			
	The lev				Ves 2	JNo 16	ZYes 2□ No			
ta	leath. feath. for: After this certificate he funeral director, page		26. Plac	ce of Death (Check of	only one)					
> >	Physician: rthis certific ral director.	No Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □		lursing Home \$Q	Residence 6	☐Other (Specif	y)			
E C	h. After t funera	27. Mannar of Death 1 Natural 5 Panding 28a. Data of Injury 1 Natural 5 Panding Panding 28b. Tima of Injury Found	28c. Injury at Work? 1 ☐ Yes 2/5		ribe how injury		otyun ward			
Division of Vital	Her of the control of	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Invastigation 2 ~ 13 - 00 16 ≥ 0 M	28f. Locat	ion (Street and r Town, Stata)	Number or Run	al Route Number.				
	To the Hospital of within 24 hours at To the Funeral D completely filled in									
	the the parties of th		9c. License number			a signed (Month,				
	F ₹ F 8	Service Service Continued of Continued Continu	OCME			UARY 14,				
	M	30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)								
	11/10	Denni > J. Chutemo 111 Penn Street	et, Baltim	nore, Mary	land 2	1201				
	State Registra	31. Data filed (Month, Day, Year) 32. Registrar's Signature	South.	2						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2000 045 Harold Alonzo Palmer tel 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location n of Death Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Deys 10 M 20 F Months 204-03-7939 88 November 27, 1911 PA Usual Residence of Deceden 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Fulton Warfordsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 White Oak Hollow Road 17267 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: White If Yes, Give Year or Detes: 1 ☐ Yes 2 XNo Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Federal Government 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First Middle, Maiden Sumame) Walter Howard Palmer Opal Ella Sharpe 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 203 White Oak Hollow Road Warfordsburg, PA 17267 Larry W. Palmer/Son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Buriaf 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/2000Warfordsburg, PA Cedar Grove Cemetery 21. Signature of Funeral Service Licentine 22. Name end Address of Facility
Grove Funeral Home, P.A. 141 W.Main St. Hancock, MD 21750-0368 23a. Pert1. Enter the disease, or company shock, or heart failure. List only one deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Onset and Deeth fmmediete Cause (Finel disease or condition resulting in death) ATHERDSCLEROTIC CARDIOVASCULAR DISTEASE 72 hous COWAESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes an autopsy performed? 2 D/No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No N Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

68760, P.O. Records, of Vital death.

Palmer

the attending physician hed for use as the burla edical = Physician/M þ Completed 88 10 Alter after death Director: /

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Madical Examples must be notified at

pernit. Pages 1 and 2 should be filed within Department of Health and Mental hygiene. Important: If Item 27 is marked other than "seny injury or other treumade event, the Mental Injury or other treumade event, the Mental

Physician

/Medical

Examiner

the

Maryland 21215-0020

Baltimore,

Director

Funeral

py

Completed

8

Certification: Division To the Hospital o within 24 hours at To the Funeral Di completely filled it edical

State Registra

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

368 MILL ST. HAGERSTOWM M 02/740

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

128365

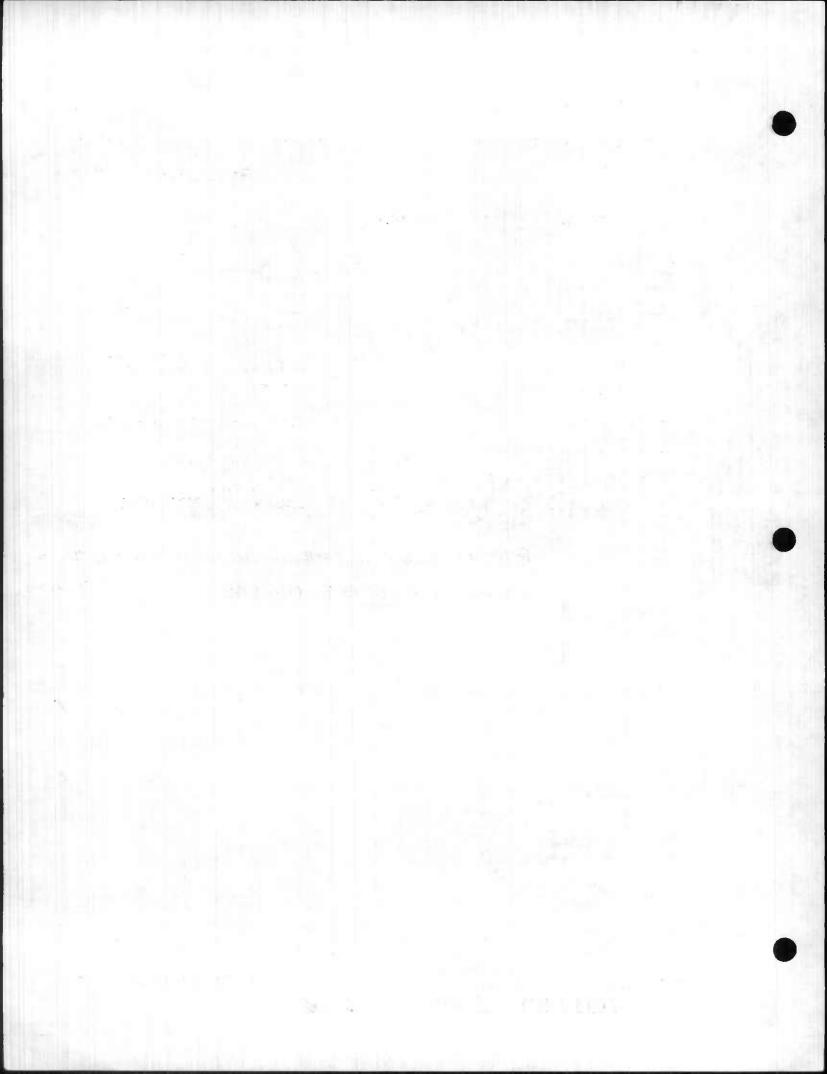
29d. Date signed (Month, Day, Year)

2.10

29a. Certifier (Check only one)

29b. Signature and title of certifier

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Alma Peaco 10 ebruary 2000 PM 4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. | Hours | Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 1 M 250 84 Yrs. 212-22-6147 Nov. 18, 1915 Va. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits Baltimore 1 XXes 2 No n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4225 Loch Raven BLVD. 21218 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 XXXIIIO 1 Never Married 2 Married Black. 1 Yes 2KMo Specify: Specify: 3 Nidowed 4 □ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 11th Grade College (1-4or 5+) Private Families Domestic 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Jackson Mary Pryor 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4225 Loch Raven BLVD. Baltimore, Md. 21218 Joan P. Rucker Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20s. Method of Disposition 20c. Location - City or Town, State 1 DXPGrial 2 □ Cremation 3 □ Removel from State Baltimore National Cemetery Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Nutter Funeral Homes, 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each she. Approximete Interval Between Onset and Deeth Sophogeal
Die to (or as a gonsequence of): Immediate Cause (Final months disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 200 No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Sother (Specify) Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Menner of Death 28d. Describe how injury occurred 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760.

To the Mospital or Attending Physician: The law requires that the death certificate be associted within £2 khours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division of Vital Records,

Physician

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29e. Certifier

29b. Signature and title of certifie

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filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0020

State Registrar

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner steted.

29c. License number

29d. Date signed (Month, Day, Year) 2000

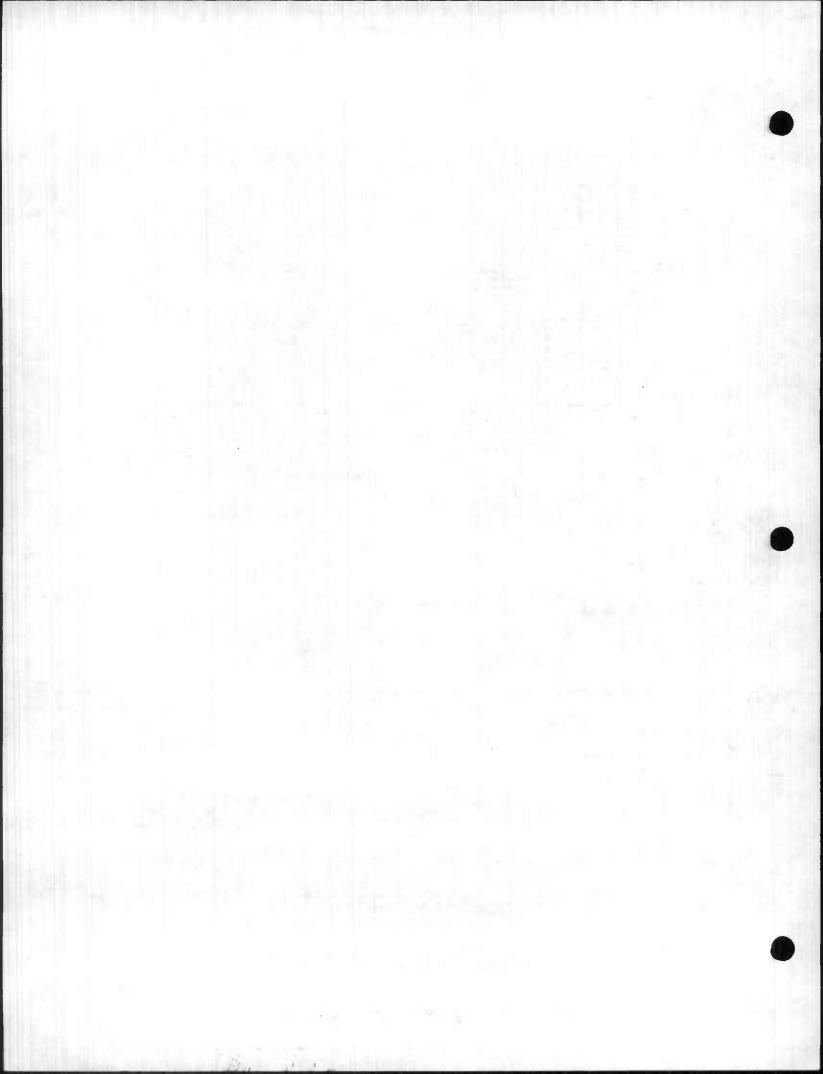
30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)

5601 Lock Raven Blud., Baltimore, ND 21239 Naiman, MD 32. Registrer's Signature

31. Data filed (Month, Day, Year)

2000 ▶ FEB1

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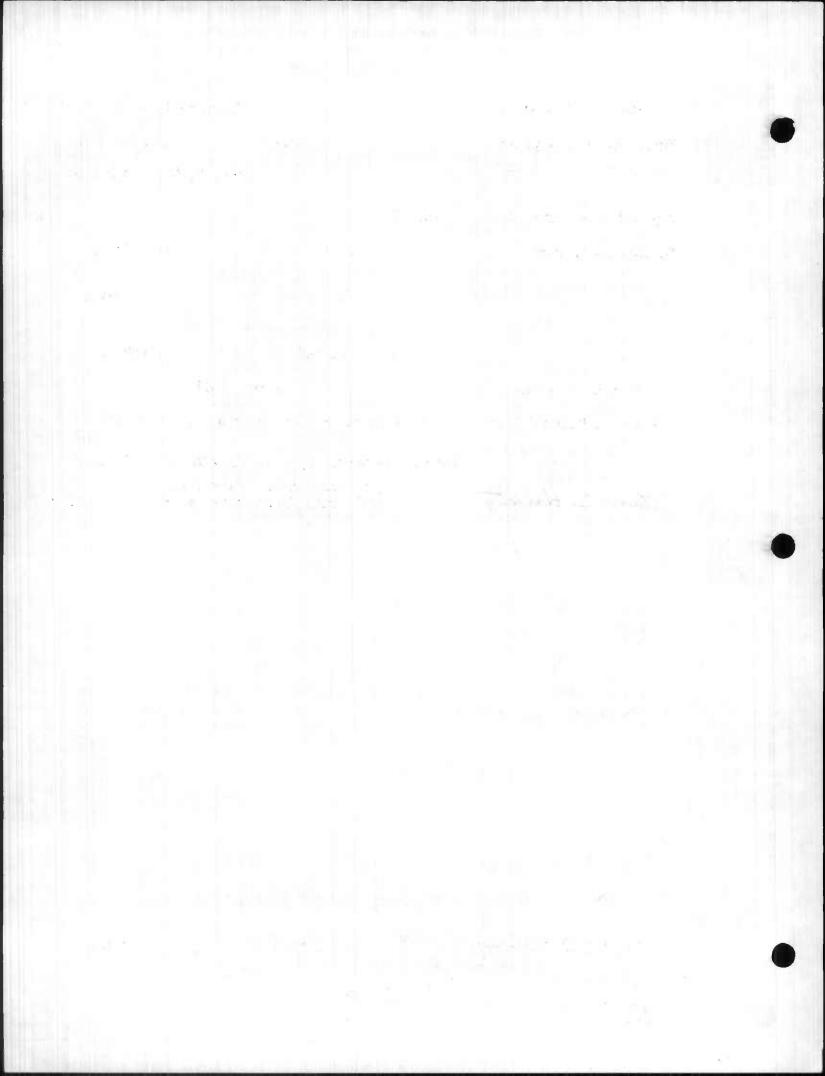
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. [,]

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:00 AM February 15,2000 Pleasants Mildred /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Arnold Future Care Chesapeake If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) **Funeral** 1 □ M 2 🕅 F Months Days Hours 216-10-9928 79 Yrs. Nov. 9,1921 Maryland Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumstic event, the Medical Eventheer was the contribution 10d. Inside City Limits 10a State 10b. County 10c City Town or Location Arnold 1 ☐ Yes 2 No Anne Arundel Maryland Directo 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 21012 United States 305 College Parkway Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Disabled Never Worked 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Elmira Hall James Luke Pleasants 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Relationship (Type, Print) 5252 Fourth Street Baltimore, MD 21225 Dorothy L. Milton/ Sister 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 2/19/2000 Beltsville, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 21. Signature of Funeral Servica Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Baltimore, MD 21286 Approximate Intervat Between Onset and Death **Physician** / Week neum oua /Medical tmmediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequenca of): 50 signed by the al Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributs to the cause of death? Duorder 1 Yss 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed ete has 1 Yes 2 No 1 □ Yes 2 □ No certificete To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 10 Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the best of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year)
29d. Date signed (Month, Day, Year)
2-15-2000 29c. License number 29b. Signature end title of cartifier \$109 RIJEHUS HWY, PASADENA, CHD 21122 C.V.CYRIAC-M.D 8109 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Anna Helen Pappas February 12, 2000 4:30PM 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care - Ruxton Towson Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplaca (Stata or Foreign Country) 1 □ M 2 X F Months Deys 577-01-7111 99 May 12, 1900 Germany Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6902 Lachlan Cir. 21239 United States 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Raca - American Indian, Black, Whita, etc. 11. Marital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) buyer department store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Frederick H. Block Augusta W. Raddatz 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) Elizabeth Yenni/sister 816 Mockingbird Lane Towson, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2/18/00 Baltimore, Maryland 21. Signeture of Funeral Service Licansee 22. Nama and Address of FedilityMitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Mully Baltimore, MD 21212 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Betw Onset and Death Infantim-Immediate Cause (Final disease or condition resulting in death) HOUNS. Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): thet initiated events resulting in death) Last Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 2 200 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner

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Division of Vital or Attending Physician:

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Funeral

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item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

offied within 72 hours effer If Hygiene. Other than "natural", or ite

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic avantal.

Baltimore, Maryland 21215-0020

the Maryland

Examiner à Completed Be 10 Certification:

bunal-transit the USB BS ŏ signed by the a page 2 s funeral in by To the Hospital within 24 hours a To the Funeral Completely filled

Physician/Medical

27. Menner of Death

1 Naturel
2 Accident

29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as attated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title-of certifie 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) H.GHILADI. M.D.

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

31. Date filed (Month, Day, Year) State Registrar FEB1 2000

32. Registrar's Signeture

28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28c. Injury at Work?

29c. Licanse number

1 ☐ Yas 2 ☐ No

D-12849

28a. Date of injury (Month, Day Year)

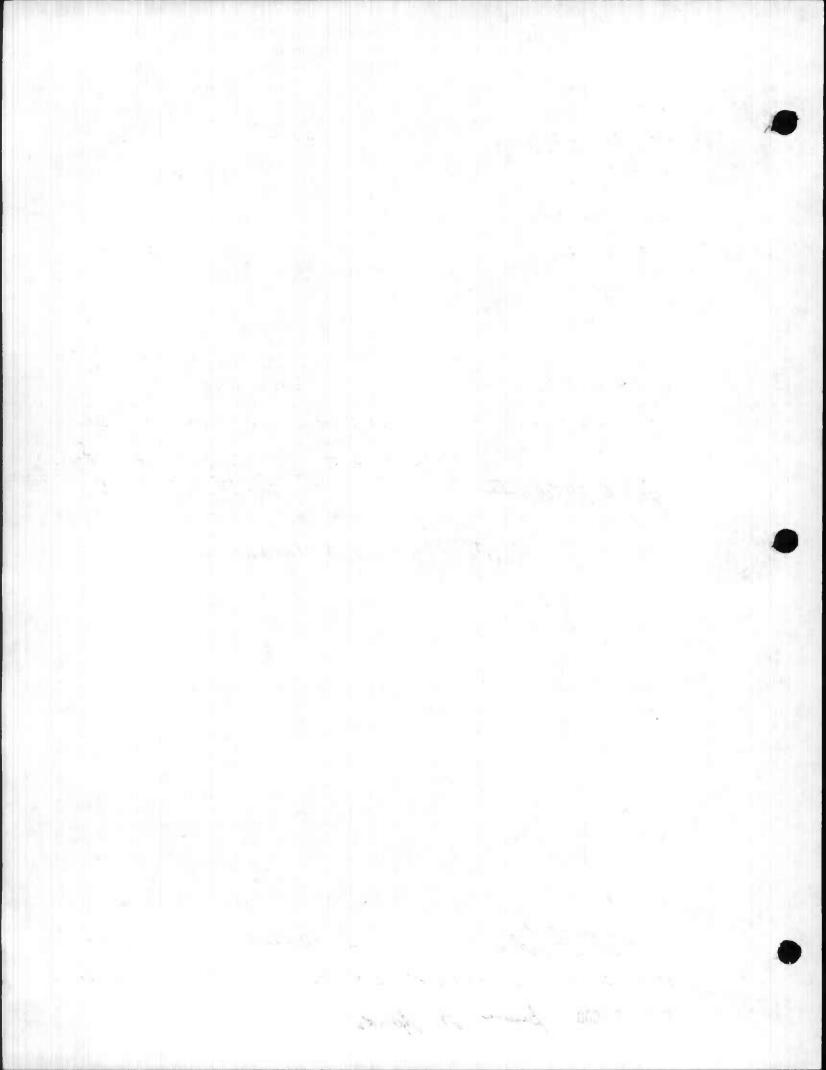
7600 OSLER Dr. TOWSON. My. 21204

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)

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Registrar **DHMH 16 Rev 6/95**

State

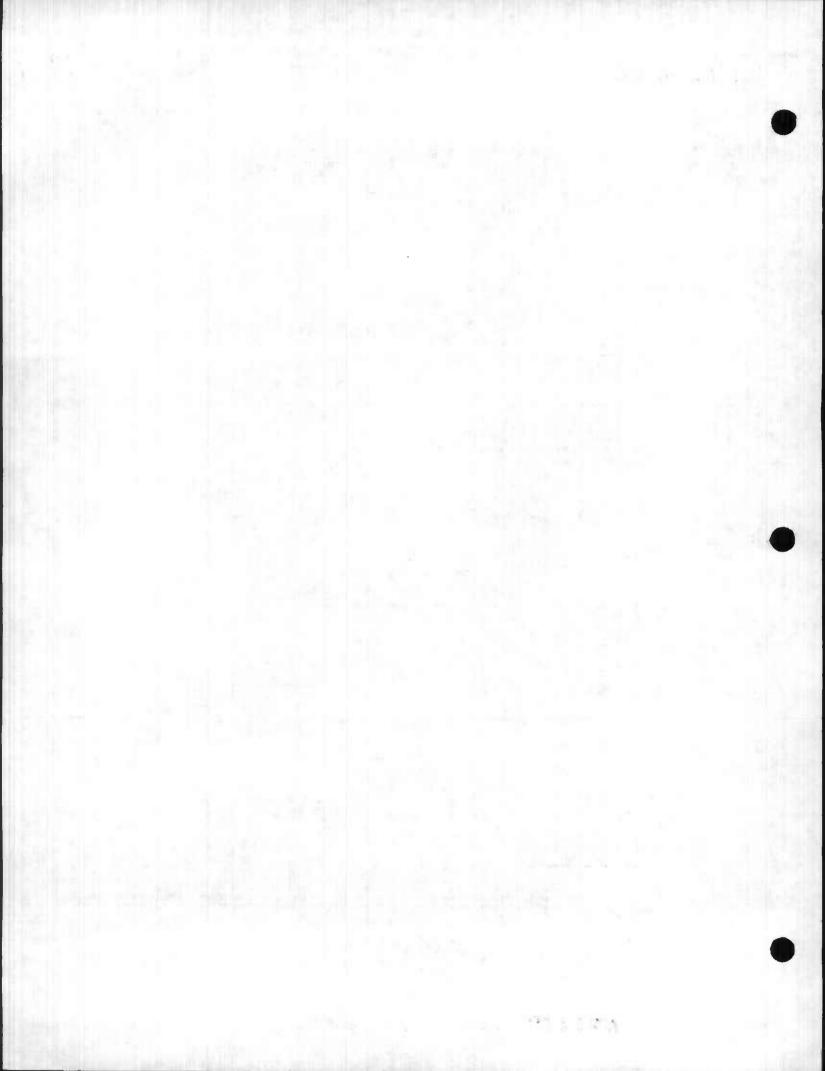
Jack M.

31. Date filed (Month, Day, Year)

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32. Registrer's Signature

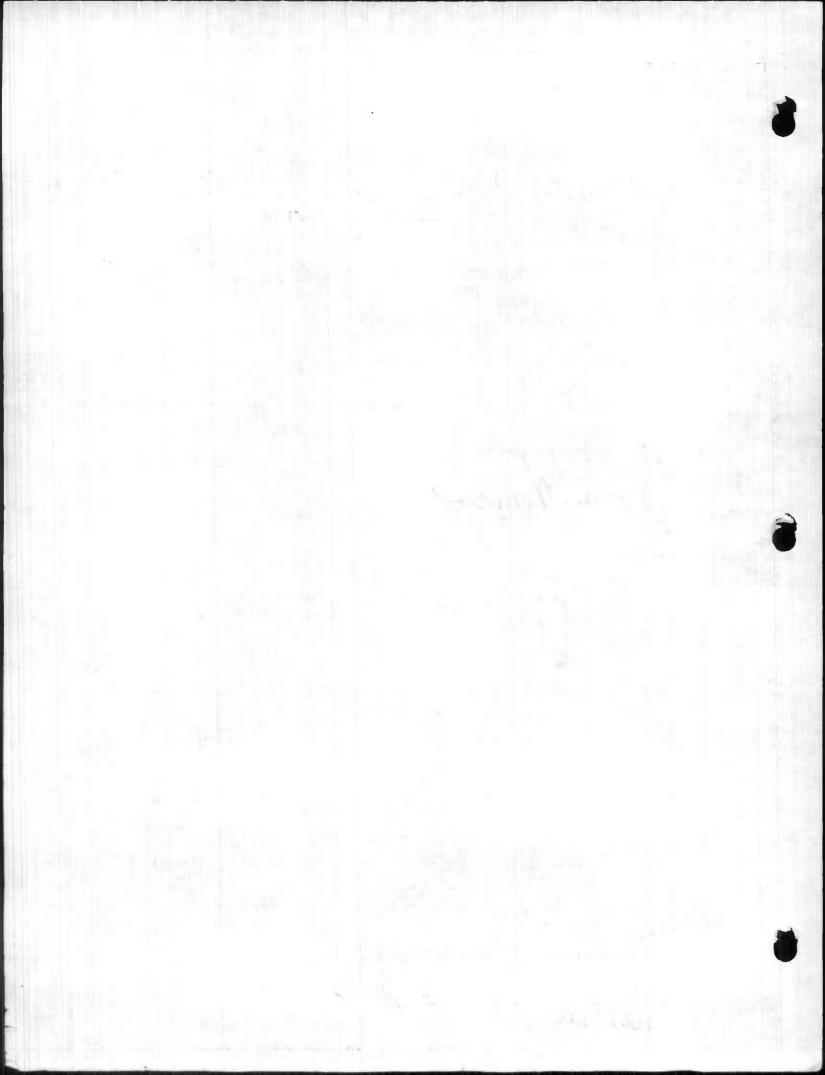
111 Penn Street, Baltimore, Maryland 21201



Registrar

2000

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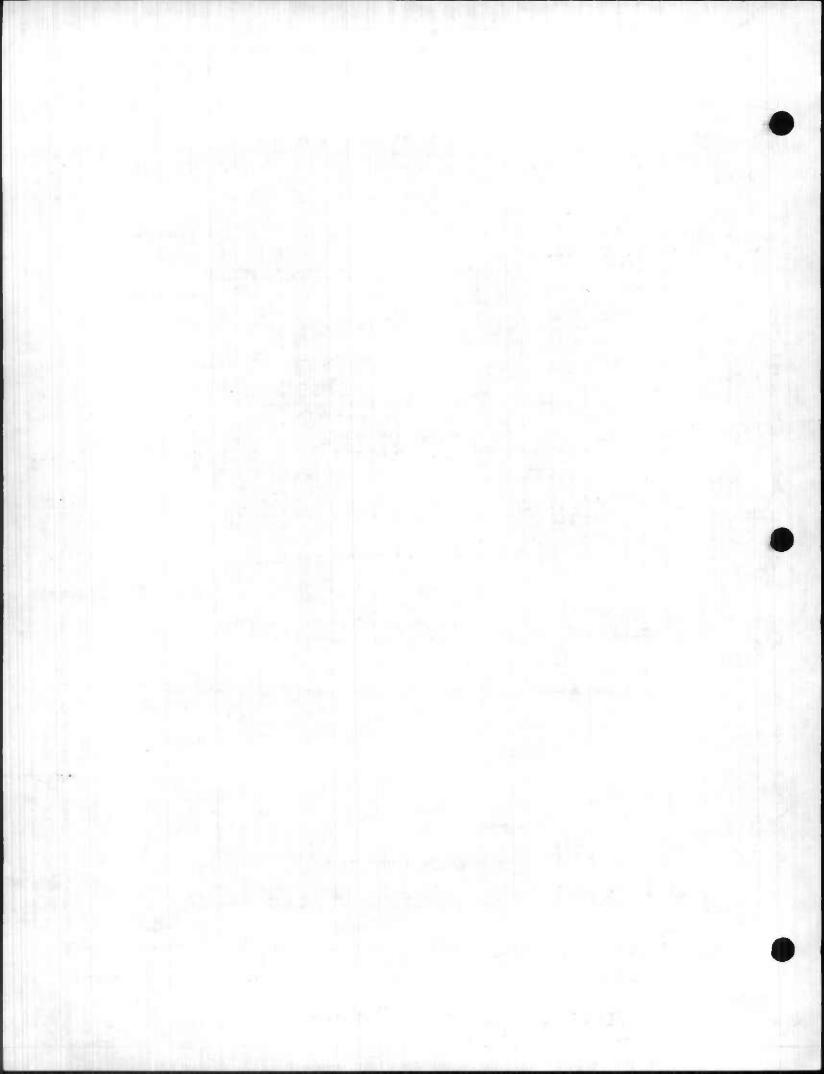
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Year **Physician** 12:15A Angela Rice February (01) 14 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Rayview Medical Center N/A Baltimore if Under 24 Hrs. 8. Data of Birth Hours Min. NOV 5, 1920 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 25 F 216-05-6638 79 MD. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show MD. N/A t√ Yes 2 No BALTIMORE Directo 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 344 ELRINO ST. 21224 USA 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. filed within 72 hours after other than "natural", or it went, the Medical Exemin 1 Yas 2V No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 10 17. Father's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surnama) Pages 1 and 2 aboutd be in ment of Health and Mental H ant: If hem 27 is marked off jury or other traumatic even å GAETANO MOSCA ROSE MARESCA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) WILLIAM RICE, JR. 344 ELRINO ST., BALTIMORE, MD.21224 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Data NE Buriat 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) OAK LAWN CEMETERY 2/17/2000 BALTIMORE, MD. 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21224 Approximate Intervel Between Onset and Death **Physician** /Medical Immediata Causa (Final Aspiration Pheumonia. disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner 2 days Uro sepsis physician and the burial-transit Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cold Agglutin Hemolytic Anemia. 5 years Box 68760, Physician/Medical Due to (or as a consequence of): . signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wara autopsy findings available prior to Completed 24a. Was en eutopsy performed? completion of causa of death? page 2 s 1 Yes 2 No 1 ☐ Yes 2 X No certificata of Vital Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 1 ☐ Yes 2 No this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Division After 1 Natural 5 Pending death. 1 Yas 2 No investigation 2 Accident after death Director: 6 ☐ Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital or /
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letely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 20303 20WO February 14,2000 anow 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 June Unevine Priview Medical Center 4940 Bastern Avenue Battimore, MD 21224 31. Data filed (Month, Day, Year) 32. Registrar's Signature State oaks Registrar FEB 1 7 2000

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year 10:45 AM 2000 12 FEBRUARY Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth HEALTHCARE BALTIMORE AGNES If Under 1 Year Months Deys If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthpleca (Stete or Foreign Country) 10M 20F Hours 215-30-9360 89 Sept. 22, 1910 Maryland Usual Residence of Decedant 10e. Stete 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane Apt. 124B 21228 United States 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican indian, Black, Whita, etc. 1 ☐ Yes 2 ☐XNo if Yes, Give Yeer or Dates: 1 Nevar Married 2 Merried 1 ☐ Yes 2 🗓 No Specify 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Teacher Special Education 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) James Grant Trout Elizabeth Elenor Rowe 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Helen V. Meiser/Neice 3005 Brookwood Road Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 2/16/00 Baltimore, Maryland Parkwood Cemetery 21. Signeture of Funeral Service Licensee 22. Nama end Addrass of Facility Hubbard Funeral Home, Inc. Homas danta U 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Pert I Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onsat end Deeth immediete Cause (Finel disease or condition resulting In death) FIVE DAYS ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of) Due to (or es e consequence of): Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 2 Accident 1 Tyes 2 No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕍 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. (Check only one) 2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steted. 29b. Signature and title of certifiar 29c. Licansa number 29d. Date signed (Month, Dey, Year)

SOLLOWAY, ANNA i or Attendi after death Director: / To the Hospital or Atterview within 24 hours after der To the Funeral Directo completely filled in by the

P.O. Box 68760,

Registrar

Physician

/Medical

Examiner

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Funeral

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, "is Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or frems 23a any injury or other traumatic event, the Men

Physician /Medical

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Certification:

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31. Dete filed (Month, Day, Year) 7 2000

RICHARD



MEDICAL RESIDENT

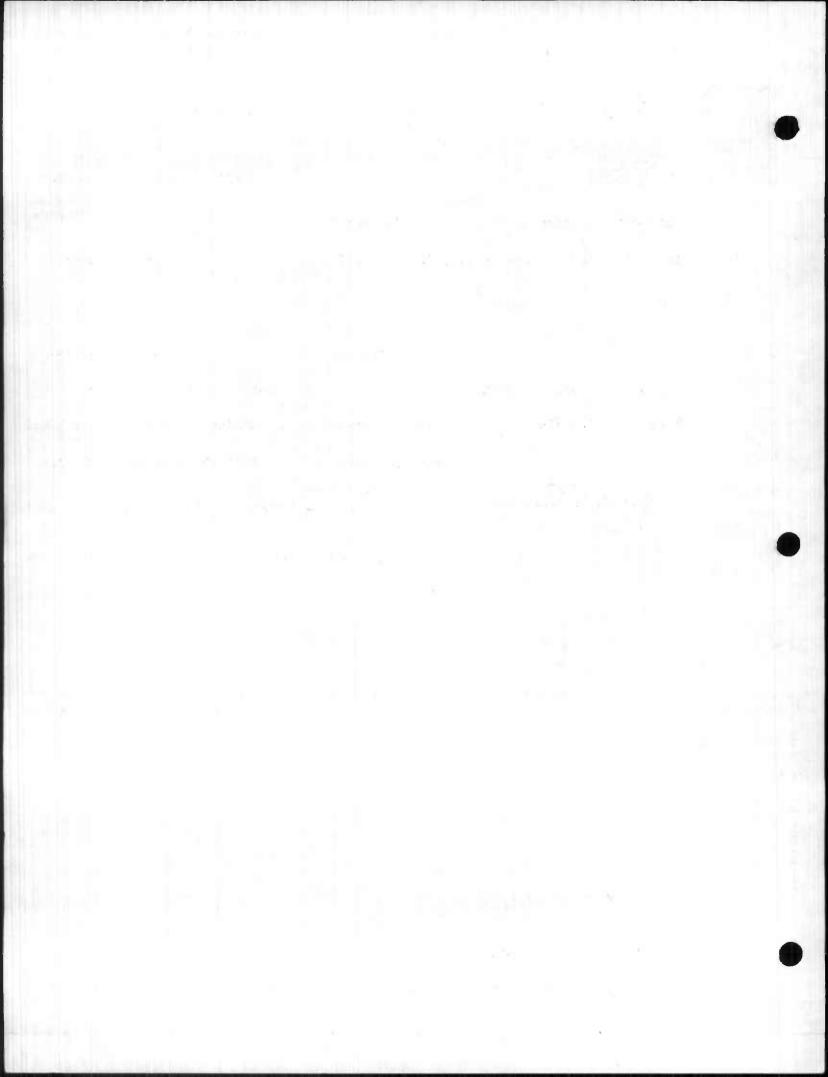
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

OFFEI

CATON AVENUE BALTIMORE MD 21229

Y13604

FEBRUARY, 12, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) Day Year SLATTERY IRMA E. FERRY 4b. City, Town, or Location of Death 720 2000 16 4a Facility Name (If not Institution, give street and number) 4c. County of Death RALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Hours | Min. | (Month, Day, Year) HOSPITAL AGNES Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthday) 216-14-0269 1 ☐ M 2 🛱 F 92 Yrs. MARYLAND Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 ☐ Yes 2 ☑ No ARBUTUS 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 1016 ST. CHARLES **AVENUE** 21229 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian. Black, Whita, etc. 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 🙀 No Specify: WHITE 3 Midowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elemantary/Secondary (0-12) Collega (1-4or 5+) TELEPHONE OPERATOR PUBLIC TELEPHONE CO. 8 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) **GEORGE EBARDT** R. LOUISE ANGER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) COCKEYSVILLE, MD VIRGINIA L. SLATTERY DAUGHTER 21 WARREN COMMON, 21030 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 02 - 181 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 2000 BALTIMORE, MARYLAND 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, 21229 MD 23a Part I. Enter the disease or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, brock, or heart feature. List only one cause on each line. Approximata Interval Between Onset and Daath Immediata Causa (Final disaasa or condition rasulting in daath) PNEUMONIA Sequantially tist conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 Yes 2 No 25. Was casa rafarrad to medicel examiner? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatient 1 Yas , 2 No 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No Invastigation 2 Accidant 6 Could not be datamined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Sulcide 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 29a. Cartifiar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

with the Maryland r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after deeth with I Department of Health end Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23s or any injury or other traumatic avent, its Mod cal Examiner must be an once.

Physician /Medical

Examiner

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page 2

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Baltimore, Maryland 21215-0020

State Registrar

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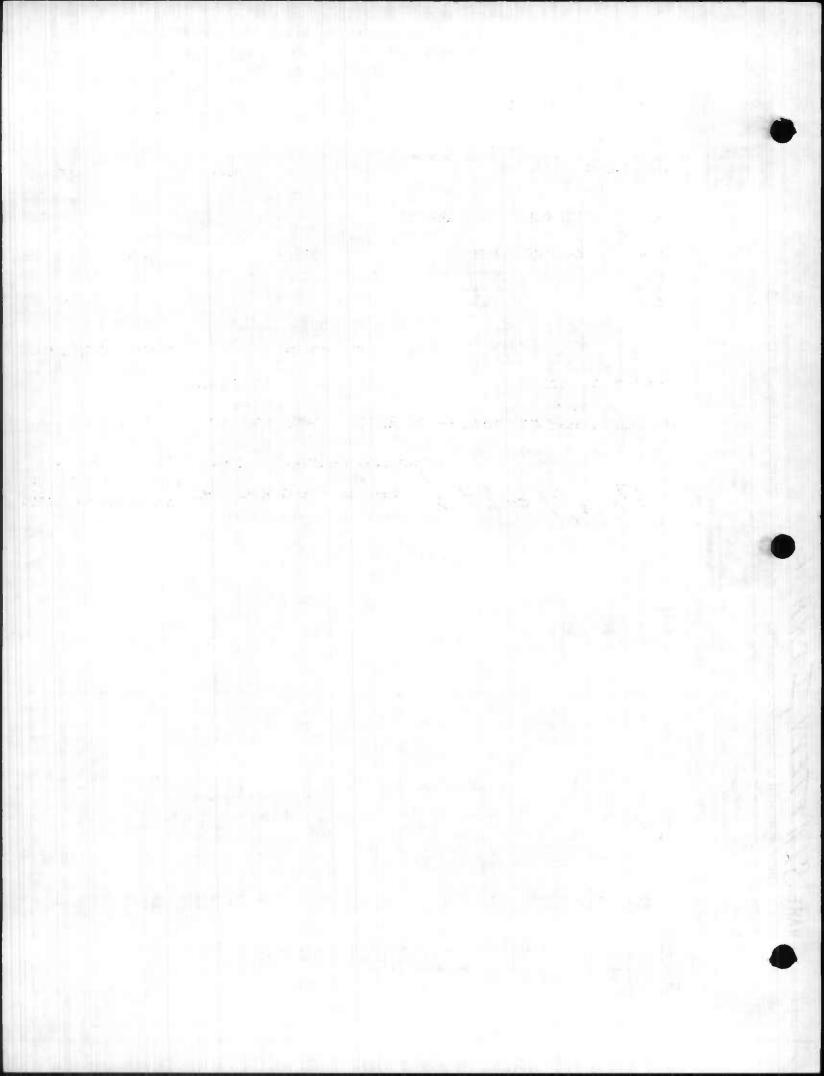
31. Data filad (Month, Day, Year)



30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

RESIDEN

2502 W-PATAPSCO AVE APTZB BALTIMORE MD21230 Dack's



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 1, 91, 6 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death Day SCHMIDT Month Ε. 02 2000 3:50 pm 11 4b. City. Town, or Location of Death 4c. County of Death CATONSVILLE BALTIMORE If Undar 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign MARYLAND

1. Decadant's Nama (First, Middle, Last) **Physician** NELLIE /Medicai 4a. Facility Nama (If not institution, give straat and number) **Examiner** CHARLESTOWN CARE CENTER | Hours | Min. | 8. Data of Birth (Month, Day, Year) | 10-06-1907 5. Social Sacurity Number Funerai Days 212-09-0825 1 ☐ M 250 F 92 Yrs Director Usual Rasidance of Decedant with the Maryland 10a. Stata 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner num be notified at 10b. County 10c. City, Town or Location MD BALTIMORE CATONSVILLE Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 717 MAIDEN CHOICE LANE, APT 8105 21228 U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedant Evar in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 1 Navar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 21215-0020 1 ☐ Yas 2 No Specify: 3 X Widowed 4 ☐ Divorcad 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) Pages 1 end 2 should be filed within nent of Health end Mental Hygiene. ant: If frem 27 Is marked other then ' Lry or other traumatic event, me Ma Elamantary/Secondary (0-12) Collega (1-4or 5+) MANAGER OLIN MATHISON CORP. 12 Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be FREDERICK EBERT NELLIE MARIE RILEY 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 10021 MILL POND DRIVE, BISHOPVILLE, MD 21813 L. COX COUSIN 20b. Placa of Disposition (Name of cemetery, crematory or other place)
WOODLAWN CEMETERY 20a. Mathod of Disposition 20c. Location - City or Town, Stata 02-15 1 X Burlal 2 ☐ Cramation 3 ☐ Ramoval from State permit. Page Department important: If any injury or WOODLAWN, MD. 2000 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Femalal Service Licenses 22. Nama and Addrass of Facility 4107 WILKENA AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 Paper. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. **Physician** Dementis /Medical tmmediata Causa (Final disaasa or condition rasulting in daath) **Examiner** Dua to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificeta be axecuted buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) ng physiclan at as the buriel Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. o Division of Vital Records, P. þ Completed performed? has 30NO certificata 1 Yas Be

Approximata Intarval Batween Onset and Death years

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1 Yes 2 No

23b. Did tobacco use contribute to the cause of death? 1 □ Yee 20(No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Wara autopsy findings available prior to completion of causa of death?

28d. Dascribe how Injury occurred

1 ☐ Yas 2 No

26. Placs of Death (Check only ons) Othar: 48 Nursing Homa 5 Rasidanca 6 Othar (Specify)

25. Was casa rafarred to medical axaminar? 1 Yas 2 No 27. Mannar of Death

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Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

28c. Injury at Work?

1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one)

1 Natural

2 Accidant

4 Homicida

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Certification: To

Medical

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14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of

MD

29c. Licansa number

29d. Data signad (Month, Day, Year)

30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print) ndich (971) Maide

char lare Catenswille MI.

State

31. Data filed (Month, Day, Year)



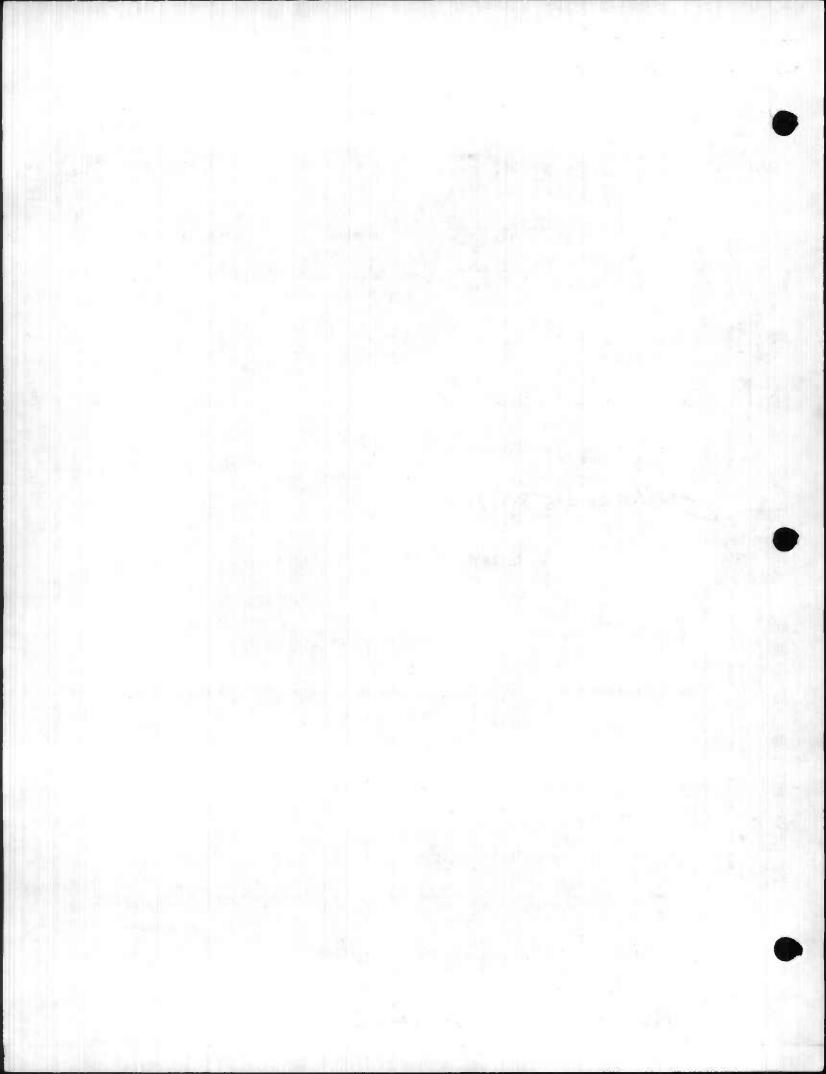
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible amend item 19aper fh G780 2/17/00 yg State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician February 18:38 10,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita of Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 2-4-195 Birthplace (State or Foreign Country) **Funeral** 1 M 20 F 50 Director 214-54-4780 Ma **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahom t then "netural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director Ma Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SIMMONds 11.5.H 5508 21215 Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 21 No Specify: Black Specify p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Edge combe Circle filed within I Hygiene. permit. Pages 1 and 2 should be filed withis Department of Health and Mental Hygiene. Importants if flem 27 is marked other than any Injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home aintenance 12th grade years 17. Father's Neme (First, Middle, Last) UNI 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Deba Debra Singley-Wite SIMMONds 5808 Avenue Balto, Md 21215 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vet -18-00 Forest 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 1215 unch F. H. Was Wabash MA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Onset and Death Physician /Medical Immediate Cause (Final incephalopai disease or condition resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated exects.) Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical å Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t à 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

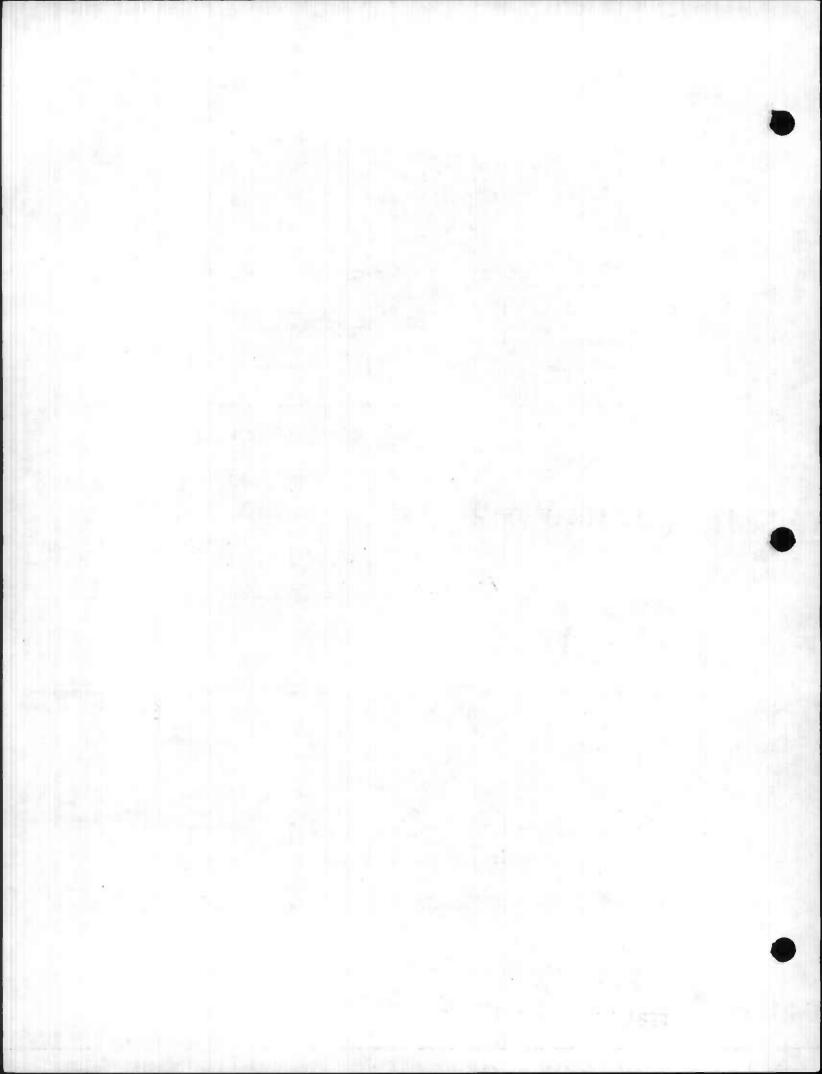
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 000 30. Name and address of person who compl eted cause of death (Item 23a) (Type, Print) west Belveder Baltimore MD pinak M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2000 Registrar FEB 1 **DHMH 16 Ray 6/95**



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Examiner	4a Facility Name (If not institution, give UNIVERSITY OF MAKE		AL CENTER	4b. City, Town, or BALTI							
Funeral Director	5. Social Security Number 6. Se 572-38-9302	x 7. Age (In yrs. last		r If Under 24 Hrs	(Month, Day	Year) 11931	9. Birthplace (State or F Country) 1931 California				
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Battimore, Roemit. Peges 1 and Department of Health Important: If I fem 27 any Injury or other tonce.	4 □ Donetion 5 □ Other (Specify) 21. Signature of Funerel Service Licens		22. Name and Add		10/00	Daiti	more,	MD			
Baff Baff Bagger	Edward A. Gregorchik 299 Frederick Rd. Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth) Adult Respiratory Distress Syndrome Dua to (or as a consequence of): Pancreatic Carcinoma										
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ovecuted in and instransit Examiner	Sequentially list conditions, if any, leeding to immediate	Due to (or as a consequence of):									
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O. Box te death cert the attendin hed for use	Part It. Other aignificant conditions cor	ntributing to death but not resulting	o in the underlying cause of	given in Part I.	23b. Did to	obacco use co	ntribute to t	he cause of death			
P. d by detach	Hepatic Sepsis	The state of the s	101	bly 4 ☐ Unknow							
2 2 8 W	Sepsis				24a. Was a perfor		avail	autopsy findings able prior to pletion of cause eth?			
f Vital Revenue of Vita					10 Y	es 20 No	10	Yes 2 No			
Of Vita Physician: this certific ral director,	25. Was case reterred to medical axaminer?	Hospitel:	Outpatient 3 DOA	Where	ath (Check only or						
- 2 00	1 Yes 2 No 27. Menner of Deeth 1. Neturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year) 281) Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred								
Division of the dead of the funeral	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No. 1) City or Town, State)									
Hoepi 24 hour Funer stely fill	29e. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my knowled ner: On the basis of examination and menner stated.	ige, death occurred at the and/or investigation, in my	time, date and place opinion, deeth occu	e, and due to the c urred at the time, o	ause(s) and ma late and place,	anner as stat and due to th	ed. ne cause(s)			
To the within comple	29b. Signeture end title of certifier	Kahm	29c. Lice	nse number	2	29d. Date signe	The second of				
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M	730. Name and address of person who or RANDHIR KI		a) (Type, Print)								

Registrar

FEB 1 7 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 4949 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Feb Marie L. Strasinger /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** Mariner Health of Bel Air Bel Air If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) DEC 23, 1908 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 G Days Min Months Hours 216-56-7740 Director Usual Residence of Decedent the Manylend 10a. State 10c. City. Town or Location 10b. County Baldwin MD Harford Director 10e. Street and Number 10f. Zip Code permit. Peges 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other treumstic event, the Medical Examples of the 2026. 21013 2712 Raynham Court Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married altimore, Maryland 21215-0020 1□ Yes 2□ No Specify: by 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed)

14. Race - American Indian. Black, White, etc. Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Homemaker Domestic 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Unk. McCrea Fred Emge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) 2712 Raynham Ct., Baldwin, MD 21013 e of Disposition (Name of Date 20c. Location - City or Town, State Warren L. Strasinger/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Metro Crematory, Inc. 2/16/00 Baltimore, 4 ☐ Donetion 5 ☐ Other (Specify)

21. Signature of Euneral Service Licenses Thomas Gregor

²² Name and Address of Facility Cremation Society of Md., Inc. 299 Frederick Rd. Baltimore, MD 21228

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

3. Time of Death

9. Birthplaca (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

1.20 Am

2000

Harford

4c. County of Death

10g. Citizen of What Country?

USA

Immediate Cause (Finel disease or condition resulting in death)

Engestive Heart

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last

- Airtic Stensis Juliar Heart Disease sufficiency mitral Requirantation

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

chemic Heart Brain Syndrome

24a. Wes en autopsy performed?

2 No

24b. Were autopsy findings available prior to completion of cause of deeth?

25. Wes case referred to medical examiner?

1 Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 ☐ Yes 2 ☐ No

1 Yes 2 No 27. Manner of Death

28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Natural 3 ☐ Suicide 4 ☐ Homicide 5 Pending Investigation 6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

29e. Certifier (Check only one) # Cartifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

State Registra

Physician

/Medical

Examiner

physicien end the burial-trensit

esn

signed by the e

has certificate ha

After this

after

To the Hospital pultin 24 hours To the Funeral completely filled

The law requires that the death certificate be executed

Examiner

Physiclan/Medicai

by

Completed

Be

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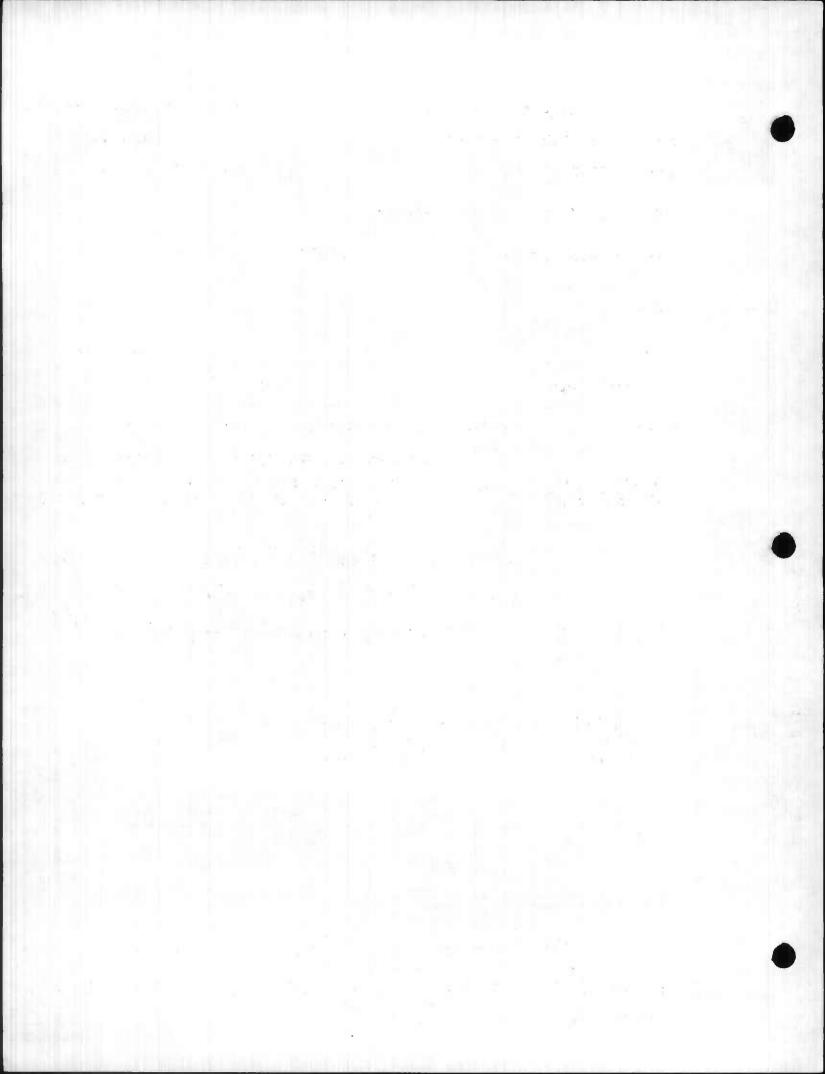
Certification:

edica

MARLE LOUISE STRASINGER

Division of Vital Records,

or Attending Physicien:



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	_				(ertifica	ite of	Death		Reg. No.			
ysician	1. Decedent's	Name (First, Middl	e, Last)						2. Date of D Month	Death Day Year		3. Time of Death	
edical	ANN				FMAN	_			FEB.	15 200		12:25AM	
er	4a Facility Na	ma (If not institution	n, giva street and	number)				4b. City, Town, o	or Location of Dea				
	JEWISH 5. Social Secu	CONVALES	CENT & I			day) If Uni	der 1 Yaar	BALTIMOF If Undar 24 H	RE R Date of B		IMORE		
	215-30		1□ M 2√XI	Trigo (my you later our mody)					n. (Month, I MAY 2	orth Day, Year) 9. Birthpla Country MD MD		place (Stete or Foreign ntry)	
	10a. State	10b. County		100	. City, Town	or Location					1	Od. Inside City Limits	
5	MD	BALTIM	ORE	В	ALTIMO	RE						1 ☐ Yas 2 ☒ No	
other mast be notified funeral Director	10e. Street and 7920 SC	Number	EL ROAD				Zip Code 208			10g. Citizen of U	What Cour	ntry?	
Jera	11. Maritai Sta	tus	12. Was D	ecedent Ever	in U,S.	13. Was De	cedent of	Hispanic Origin?	(Specify Yas or N		ce - Amaric		
		Married 2 Mar	ied 1 ☐ Ye	Forces?			DY = N	ban, Mexican, Pu	arto Hican, etc.)		ck, White,		
by	3X Widow	red 4 Divorced	If Yes, Year o	or Dates:		1 LI Yes	2/2 No	Specify:		Specia	WHIT	TE	
Be Completed		15. Decedent's Education (Specify only highest grade completed)				ecedent's U Give kind of	work done	during most of w	vorking	16b. Kind of B	Business/In	dustry	
Idu	Elementary/	(lementary/Secondary (0-12) College				ESLAD	usa retin	9d)		DEPT. S	TORE		
ပ္ပ	17 Esther's M	ama (Firet Middle	I act)		טחט	- Lund		18 Mothar's N	eme (First, Midd				
o Be	ABRAHAM	ather's Name (First, Middle, Last) RAHAM FLAX				X			A	HARRI			
To	19e, informan	t's Name/Relations					dress (Street end Number or Rurel Route Number, City or Town, State, Zip Code) DDCOURT RD. BALTIMORE, MD. 21209						
			/ 50IV	2	0b. Place of D			I KD. Dr	Date	20c. Location		own State	
		i 2 ☐ Cremation tion 5 ☐ Other (S		om State	cemetery. ETACH	cremetory of	r othar pl	ace)		OO ROSED			
n	23a. Part1. Er shock, o	ntar tha disaasa, or r heart failure. List	-		death. Do no	t enter the m	ode of dy	ERSTOWN ring, such as cerd	iac or respiratory	KESVILLE arrest,			
	Immediata Ca diseasa or co resulting in de	ndition	a. Po	elm	to (or es e co	y Ev	ubol	ers m erseene		,	T		
ine			- Ce	rebri	vasc	rula	NO	diseeux	c, Str	oke			
i Examiner	Sequentially lift any, leading ceuse. Enter Cause (Disease)	st conditions, to immediate Underlying	S		to (or es a co						1		
dicai	trat miliated e	AGLIC2	6		to (or as a co				0				
			d	713 he	umer	105 0	dise	ease,	Logre	sive	1		
clan									•				
/ Physician/Me	Pert II. Other s	ignificant condition	T	\			g ceuse g	iven in Part î.		d tobacco use co	ontributs t 3 ☐ Pro	o the causs of death?	
Completed by									24a. Wa	as an autopsy formed?	al v	fere autopsy findings railable prior to omplation of causa death?	
THIC									15	Yes 2000		□Yes 2□No	
		referred to medice						26 Place of F	Death (Check only	/			
To Be	examiner?		Hospital:	☐ Inpatient	2□ER/Outo	atient 3	DOA O	ther . I	Home 5 Re		her (Speci	(fy)	
	27. Menner of 1 Natura 2 Accide	Death it 5 ☐ Pendir	28a. Da	ate of tnjury Month, Dey Yea		ne of	28c. tnji			e how injury occu			
Certification:	3 Suicid	le 6 Couid	inad (00. 1)	ace of Injury - uilding, etc. (S)	At home, fam	n, street, fac	tory, office		281, Location City or 7	(Street end Num own, State)	ber or Run	al Route Number,	
Aedicai Certifi	29e. Certifier (Check on		Examiner: On the	e basis of axa				time, date and pia opinion, death oc					
京	one)		and n	nanner steted.									

To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: Completely filled in by the

30. Name and address of person who completed cause of death (Hern 23a) (Type, Print)

David J. Penn MD 3635 Old CT Rd Suite 610 Pikes nile MD 21208 31. Date filed (Month, Dey, Year) State Registrar

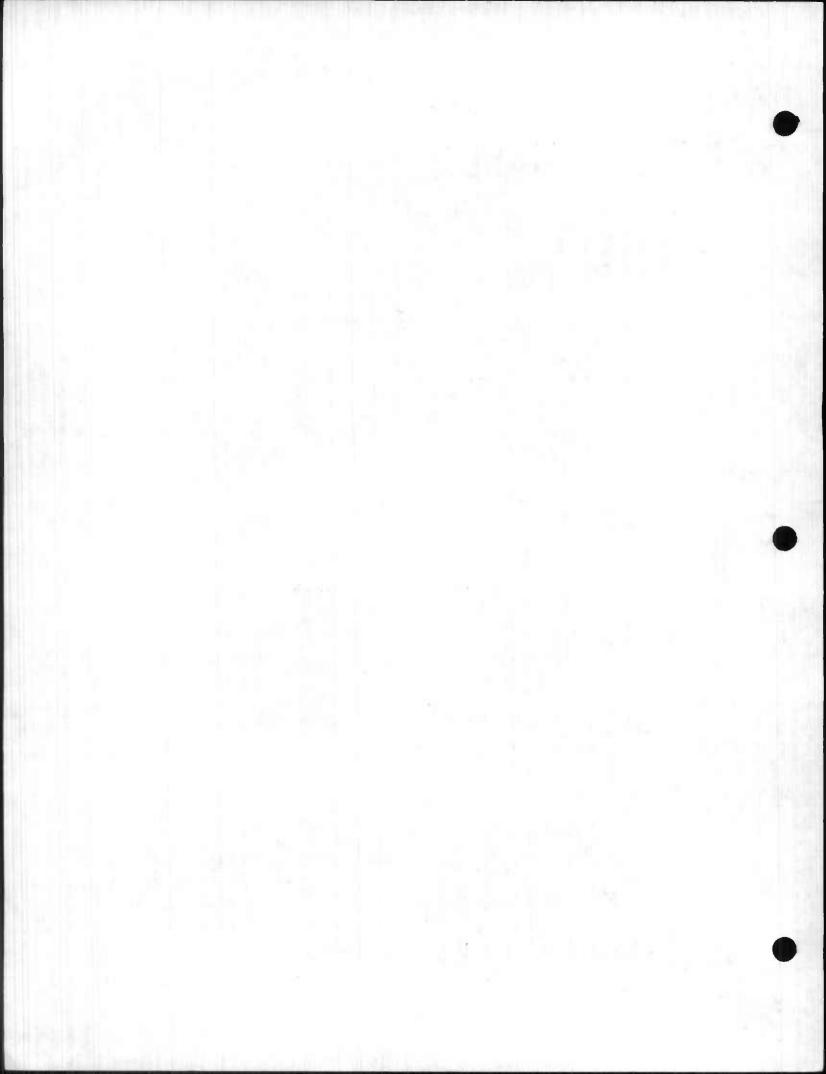
29b. Signature and title of certifier

32. Registrar's Signature

29c. Licanse number

D29928

29d. Date signed (Month, Day, Year)



PI	ease '									II Coples		0	_	
		State of	of Ma	ryland .				Health a Death		Mental Hy	_		0 (04951
1. Decedent's Name (First, M	liddle, Las	1()			061	incai	6 01	Deali		2. Dete of D	Reg.	No.	-	3. Time of Death
MARY GE	RTRU	DE	STEV	VART						Month FEB	12	Day 200	Year	6:25 P. M
4a Facility Name (If not institu	ution, give	street and nu	ımber)					4b. City, To	wn, or L	ocation of Deal		4c. County	of Deeth	
FUTURE CAR	RE	HOMEWO	OD					BALT	TIMO!	RE				
5. Social Security Number 217 – 16 – 0682	6. Se	9x ↑ □M 2 %]F	-	(In yrs. last	birthday) Yrs.	If Under Months	Days		24 Hrs. Min.	B. Dete of Bi (Month, D OC 3	rth ay. Ye	714	9. Birth	plece (State or Foreign
Usual Residence of Decedent														
10e. State 10b. Cou	unty			10c. City, T	own or Lo	cation								10d. Inside City Limits
MARYLAND				В	ALTI	HORE								1 VYes 2 No
10e. Street and Number						10f. Zip	Code				10g.	Citizen of	What Cou	niry?
2640 RIDGLEY	Y ST	REET			,	21	230					USA		
11. Marital Status 1 Never Married 2 N 3 Widowed 4 Divor	1. Marital Status 1. Wes Decedent Ever in Armed Forces? 1. Never Married 2. Married I 1. Wes Decedent Ever in Armed Forces? 1. Never Married 2. Married II 1. Wes Decedent Ever in Armed Forces?					Wes Deced If Yes, specification	cify Cul	ban, Mexica	igin? (Sp n, Puerto				ck, Whita,	
15. Dece (Specify only high	dent's Edi)	1	16a. Decedent's Usuel Occupation (Give kind of work done during most of work)					cing	168	o. Kind of B	usiness/In	dustry
Elementary/Secondary (0-1 12	2)	College (1-4or 5	+)		DO NOT U OUSEW						НО	USE	
17. Father's Name (First, Mide LLOYD	die, Last) COOK							18. Moth		e (First, Middle ENIA		den Sumer		
19a. Informant's Name/Relati	ionship (7	ype, Print)		1	19b. Meilir	ng Address	s (Stree	at and Numb	er or Rui	ral Route Numb	ber, C	ity or Town	State, Zij	Code)
ARNETTA HUI	DSON				440	6 MOU	NTV	IEW RO	DAD,	BALTIM	ORE	E, MAI	RYLAN	D 21239
20a. Method of Disposition XX Burial 2 Cremati 4 Donation 5 Other			Stete		etery, crer	sition (Nem netory or d HILL	other pla	ece) ETERY	1	Date 2/16/00		ROOKK		
21. Signature of Funeral Serv	Co Licens	- Oct	7							L SER, BALTIMO			YLAND	21217
23a. Part1. Enter the use and shock, or heart fallure.	i or comp List only o	lications that one cause on	daused each lin	the death. [Do not ent	er the mod	le of dy	ing, such ss	cardiac	or respiretory	errest,		1	Approximate Interval Between Onset and Deeth
Immediate Cause (Final disease or condition resulting in death)		8	Phyl	Une to for as	D	SC450		_			_		1	
		b		Se to (or as	a curisec	poerioe or):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated ments)	Į	C	(Due to (or as	a conseq	juence of):							1	

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important; it lisms 27 is marked other than "natural", or thems 23s or 23s-f show yillury or other traumatic event, the Medical Examples must be notified at edge.

Baltimore, Maryland 21215-0020

Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the estending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Medical Certification: To

Division of Vital Records, P.O. Box 68760.

Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

Funeral Director

Due to (or es a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contributs to the causs of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed?

1 ☐ Yes 2 ☐ No

1 Yes 2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 000 Other: Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury al Work?

5 Pending investigation 1. ENatural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

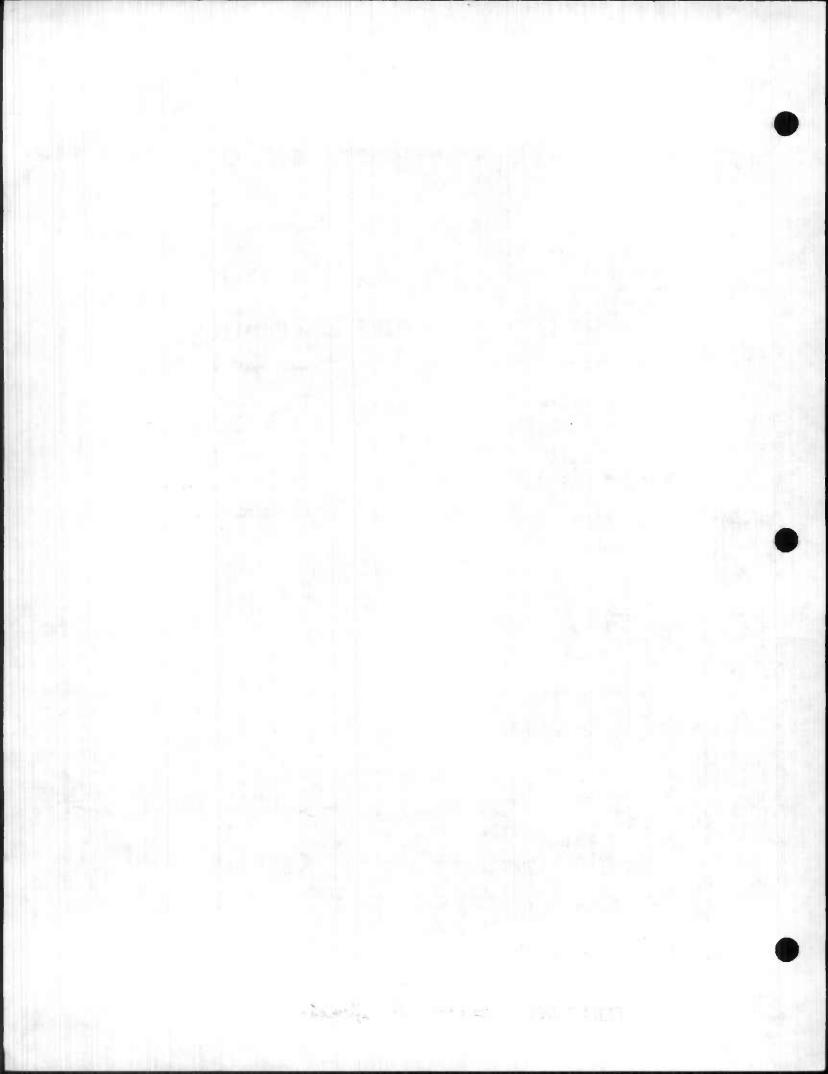
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one)

29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Raymond Miller mo D47683 2/15/00

30. Name and alidress of person who completed cause of death (Item 23a) (Type, Print)

Raymond Miller 2 31 Dale filed (Month, Day, Year) Mari Street Soute 32. Registrer's Signeture FEB17

State Registrar



Physic /Medi Examí

Funeral Director

/Medical Examiner

Please Type or Print in Black Indelible Ink	Assure Ali Copies	Are Legible.	1:9	52
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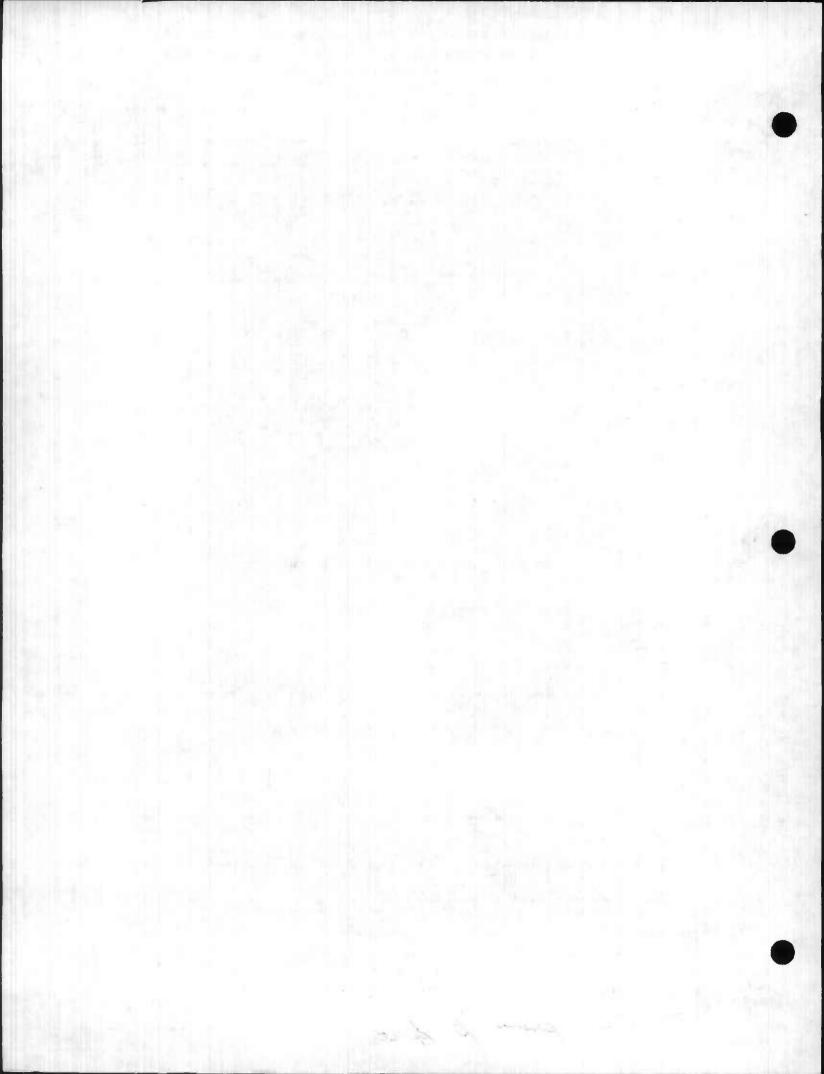
State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Name (First, Middle, Las		00,	rtificate of	Death		Reg. No.		
CIVA DICE	, and the second		37.1		2. Date of Do	eath Day	Year	3. Time of Death
ELVA RICE	SWAYNE				FEBRUA		2000	3:30 A.M
4a Facility Neme (If not institution, give	The state of the s				or Location of Deal	th 4c. Coun	ty of Death	
SINAL HOS					TIMORE		N/A	No. of the second
	7. Age (In yrs	. last birthday) Yrs.	Months Days	Hours N	lin. (Month, D	rth ey, Year) or 9,1903	9. Birthpl Coun Mary I	lace (State or Foreig try) and
Usual Residence of Decedent 10a. Stete 10b. County	10c C	ity, Town or Lo	cation				11	0d. fnside City Limits
Maryland N/A		ltimore						1 Tyes 2 □ No
10e. Street and Number 640 Deepdene Road			10f. Zip Code 21210			10g. Citizen of		try?
11. Merital Stetus	12. Wes Decedent Ever in I	J,S. 13.)	Was Decedent of I	lispanic Origin?	(Specify Yes or N	o- 14. Ra	ca - America	
1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes XX No		Jeno Hican, etc.)	Spec	ack, White, o ity: Whi	
15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	oation during most of	working	16b. Kind of I	Business/Ind	lustry
Elementary/Secondary (0-12)	College (1-4or 5+)			a)		0 11-		
17. Father's Neme (First, Middle, Last)		Haller	maker	18. Mother's	Name (First, Middle	Own Ho		
William Rice					ie Taylor			
19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street		Rurel Route Num!	ber, City or Town	n, State, Zip	Code)
Nancy E Henry	DTR	1235 T	imber Turn	Arnold M	aryland 210	12		
20a. Method of Disposition		Piece of Dispo	sition (Name of matory or other ple	(ea)	Date	20c. Location	- City or To	wn, State
1)OBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		11 Cemeter		2/18/00	Towson,	Marylar	nd
21. Someture of Funeral Service Licen		•	. Name end Addre		Mitchell-W		-	
Donnie d.	Non pil		6500 York I	Road Balt	imore, Mary			Tole Inc.
23a. Part1. Enter the disease, or corporations, or heart failure. List only	plications that caused the dea							Approximate Interval Between
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	bDue to (or as a conseq	quence of):					
Cause (Disease or Injury that initiated events	•							
resulting in death) Last	Due to (or as a conseq	uence of):			1.5	i	
resulting in death) Last	Due to (or as a conseq	uence of):				i 	
resulting in death) Last	d			ven in Part I.		,		the cause of death
resulting in death) Last	d			ven in Part I.		tobacco use c		the cause of death
Part ff. Other algnificant conditions or	d			ven in Part I.	1 = 24a. Wa	,	3 Prot	bably 4 Unknown
resulting in death) Last	d			ven in Part I.	1 = 24a. Wa:	yee 2 No s an autopsy omed?	3 Prot	era autopsy findings ailable prior to mpletion of cause death?
Part ff. Other algnificant conditions of	d				24a. Warperi	s an autopsy omed?	3 Prot	bably 4 Unknown
Part ff. Other algnificant conditions of axaminer?	d	sulting in the u	nderlying cause gi	26. Place of	24a. Warperl	yee 2 No s an autopsy ormed? Yes 2 No one)	3 Prot	pebly 4 Unknown under autopsy findings silable prior to mpletion of cause death? Yes 2 No
Part ff. Other algnificant conditions of axaminer? 1 □ Yes 2 ☑ No	d	sulting in the u	nderlying cause gi	26. Place of her: 4 \(\) Nursin	24a. Warperl	Yes 2 No	3 Prot	pebly 4 Unknown under autopsy findings aliable prior to mpletion of cause death?
Part ff. Other algnificant conditions of axaminer?	d	sulting in the u	nderlying cause gi	26. Place of her: 4 \(\) Nursin	24a. Warperl	yee 2 No s an autopsy ormed? Yes 2 No one)	3 Prot	pebly 4 Unknown under autopsy findings silable prior to mpletion of cause death? Yes 2 No
25. Was case referred to medical axaminer? 1 □ Yes 2 □ No 27. Menner of Death 1 □ Natural 5 □ Pending	d	Sulting in the understanding i	nderlying cause gi	26. Place of her: 4 □ Nursin ry at rk?	24a. Warperl 24a. Warperl 1 □ Death (Check only) g Home 5 □ Res 28d. Describe	Yes 2 No one) iidence 6 0 how injury occi	3 Prot	pebly 4 Unknown under autopsy findings silable prior to mpletion of cause death? Yes 2 No
25. Was case referred to medical axeminer? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Ph	d	sulting in the understanding i	nderlying cause gi	26. Place of her: 4 □ Nursin ry at rk? 1 Yes 2 □ No	24a. Wa: peri 1 Death (Check only g Home 5 Res 28d. Describe 28f. Location City or To	Yes 2 No one) idence 6 Oo how injury occi (Street and Number, State)	3 Protection 24b. We say condition of the condition of th	bebly 4 Unknown under autopsy findings sitable prior to impletion of cause death? Yes 2 No
25. Was case referred to medical axaminer? 1 Yes 2 No 27. Menner of Deeth 1	d	sulting in the understanding i	nderlying cause gi	26. Place of her: 4 Nursin ry at rk? I Yes 2 No	24a. Wa: peri 1 Death (Check only g Home 5 Res 28d. Describe 28f. Location City or To	Yes 2 No one) idence 6 Oo how injury occi (Street and Number, State)	24b. We ave con of a street (Specific unred street). And on the control of the co	pebly 4 Unknown under autopsy findings attable prior to impletion of cause death? Yes 2 No Who if Route Number, tated. on the ceuse(s)
25. Was case referred to medical axaminer? 1 Yes 2 No 27. Menner of Death 1 Natural Investigation Inv	d	Sulting in the understanding i	nderlying cause gi	26. Place of her: 4 Nursin ry at rk? Yes 2 No	24a. Wa: peri 1 Death (Check only g Home 5 Res 28d. Describe 28f. Location City or To	Yes 2 No one) iidence 6 O how injury occi (Street and Nun own, State)	24b. We ave con of the state of	pebly 4 Unknown under autopsy findings attable prior to impletion of cause death? Yes 2 No Who if Route Number, tated. the ceuse(s)
25. Was case referred to medical axaminer? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signeture end title of certifier	d	Sulting in the understanding i	nderlying cause gi	26. Place of her: 4 Nursin ry at rk? I Yes 2 No	24a. Wan period of the control of the coursed at the time	Yes 2 No one) idence 6 Oo how injury occi (Street and Nun own, State) e cause(s) end r, date and place	24b. We ave con of the state of	pebly 4 Unknown under the
25. Was case referred to medical axaminer? 1	d	sulting in the unsulting in the unsultin	nderlying cause gi	26. Place of her: 4 Nursin ry at rk? Yes 2 No	24a. Wan period of the control of the coursed at the time	Yes 2 No s an autopsy ormed? Yes 2 No one) idence 6 O how injury occi (Street and Nun own, State) c cause(s) end r date and place	24b. We ave con of the state of	pebly 4 Unknown under the unit of the unit

ORIGINAL

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Sta Registr

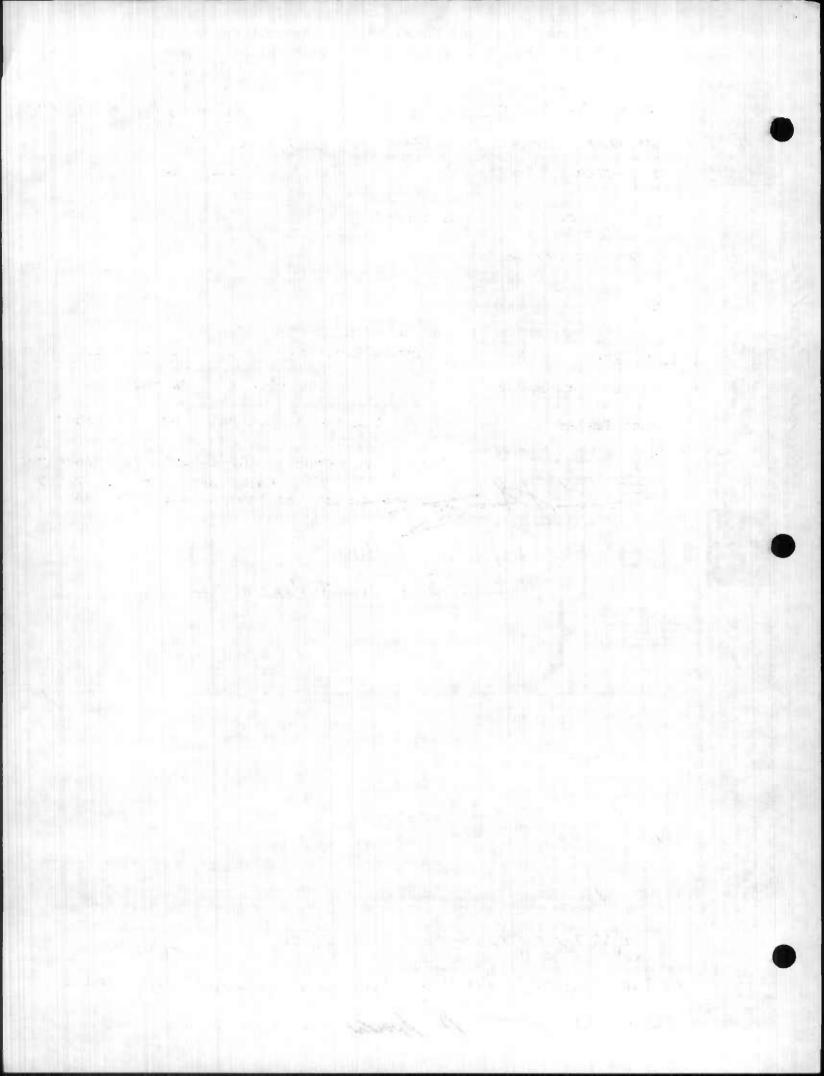


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedent's Nama (First, Middia, Last) 1115 AM **Physician** rebruary 15, 2000 Trader L. Laura /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner 40spital saltimore maryland General if Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 9. Birthplaca (Stete or Foreign Country)

KY 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Deys 1 M 2 F 62 219-26-7709 Director 02-01-38 Usual Residence of Decedent 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at the Meryla MCMyes 2 No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21212 504 Chateau Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American indien. Bleck, White, etc. 1 Nevar Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black P 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Maryland Gen. Hosp Unit Secretary 12th Grade h end Mental Hygie 17. Fether's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumeme) Lelia Shenault Shenault James 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 540 Hammond Street Salisbury, MD. 21804 Department of Health Important: If Item 27 Onita Parker 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetlon 3 Removal from State 4 Donation 5 Other (Specify) 6 Israel Mem. Cemetery 02-19-2000 Princess Anne any injury 22. Nama end Address of Fecility Baltimore, Maryland 21202 21. Signeture of Funerel Service Licensas M.C. March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused in shock, or heart fellure. List only one cause on each line. Do not enter the mode of dying, such as cerdled or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) **Examiner** Examiner attending physicien end for use as the bunel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events certificate be exec Physician/Medical thet initieted events resulting in deeth) Last Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 Division of Vital Records. à 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 inpatient 2 ER/Outpatient 3 DOA After this Dete of Injury (Month, Dey Year) 27. Mengér of Deeth 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending invastigation 2 □ No death. 1 Yes 2 Accident ofter death 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 | Homicide 8 To the Funeral To the Funeral Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print) General Hospital m. D. 40 31. Dete filed (Month, Dey, Year, 32. Registrer's Signeture State

State Registrar



			1 Decedent's N	ame (First, Middla, L	eatl		Cer	tificate o	f Death	l a Date	Re of Death	g. No.		2 Time of Death
	Physicia	an	T. Decement's No							Mor	ith	Day	Year	3. Tima of Death
Ę,	/Medic	al			yn Tharp				4. 65. 7	FE			000	9:55 PM
Ä	Examin	er			va street and number)					, or Location o	r Death	4c. County		
				Maris				771	Timor				timo	
	Funeral		5. Social Security			ge (In yrs. la	st birthday)	If Under 1 Yes		Min. 8. Date	of Birth oth, Day,	Year)	9. Birthpla Countr	ace (Stata or Foraign
	Director		410-58		10 M 20 F	66	Yrs.			JUI	X_31	, 1933	Tenn	essee
	pg .		Usual Residence	10b. County		10c City	Town or Loc	ration					110	d. Insida City Limits
	aryta a	2	MD	Balti	more		Baltin						10	1 Yas 2 XNo
	deeth with the Maryland me 23a or 28a-f ahow me the notified at	ct			more	1.	alti							**
	世 る 2	H	10e. Street and I	Number				10f. Zip Code			10	g. Citizen of V	Vhat Countr	y?
	₹ 23°	63	9803 I	Lang's Ro	d., Apt.,	, H		2:	1220			USA		
	9 8 5	Funeral Director	11. Marital Status	s	12. Was Decedent Armed Forces?	Ever in U,S	i. 13. V	Vas Decedent o	f Hispanic Origin Joan, Mexican, F	? (Specify Yes	or No-		e - Amarica k, White, et	
020	urs afte	þ		arried 2 Married	1 Yes 2 Note of Yes, Give Year or Datas:			☐ Yes 2☐XN					Specify: White	
5	2 ho	to de	40-	15. Decedant's E	ducation		16a. Deced	ent's Usual Occ	upation	d over didner	1	6b. Kind of Bu	usiness/Indu	ıstry
-	Pilo Z	Die		econdary (0-12)	College (1-4or	5.1	lifa. D	O NOT use reti	ne during most o red)	during most of working d)				
7	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f ahow eny Injury or other traumatic event, the Mandall Estation man be notified at once. To Be Completed by Funeral Director		12	0 12/	0011090 (1 401)	347	Home	emaker				Do	mesti	ic
alla			17. Father's Nam	ne (First, Middla, Las	1)				18. Mother's	Name (First, I	Middle, M			
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2	D D D D D D D D D D D D D D D D D D D		19a. Informant's	Name/Relationship	(Type, Print)		19b. Mailine	Address (Stre	et and Number				State. Zip C	Code)
Ĕ	alth ed 27 le		Robert Harvey/Son 9803 Lang's Rd. Apt. H E											
ນົ	Heal Heal	ŀ	20a. Method of D			20b. Pla	ce of Dispos	ition (Nama of		Date		Oc. Location -		
altillo	Pages nent of in int: If its iny or o		1 🗆 Burial	2 Digremation 3	Removal from State			atory or other p						
	tant tant			n 5 Othar (Speci		Me			, Inc.	2/15/00)	Baltim	ore,	MD
0	Depart Importuenty Injury		21. Signature of	Funeral Service Lice	nsee	10	22. Cr	Name and Add	ress of Facility	ietv o	f M	arvlar	nd T	nc
	40560		Davis	MCD.	ma 100 11a	M	2.9	9 Fred	lerick	Rd. B	alt	imore	MD.	21228
			23a. Part1. Ente	or the disease, or con	plications that caused one cause on each li	d the death.	Do not ente	r the mode of d	ying, such as ca	rdiac or respire	tory arre	st,		Approximata Interval Between
S	Physician			,										Onsat and Death
K.	/Medical		Immediate Caus	e (Final		CARDT	OMYOPA	ТНҮ					1	
	Examiner		disease or condition rasulting in death) CARDIOMYOPATHY a. Due to (or as a consequence of):											
		9				Due 10 (01	as a consequ	Jerica Orj.					1	
	betu brisit	Examiner			b	Due to fee								
-	n an	EXB	Sequentially list if any, leading to cause, Enter Un Cause (Disease	conditions, immediate		Dua to (or	as a consequ	rence or).					1	
5	ificate be executed g physician and as the burlet-transit	8	Cause (Disease that initiated eve	or injury	C	- 17 7 7							1	
2	phy:	edical	resulting in death	h) Last		Due to (or	as a consequ	ience of):						
4	ding				d				_					
3	itten or u	Physician/M											1	
5	bed the	18	Part II. Other sign	nificant conditions	contributing to death b	ut not resul	ting in the un	derlying cause	given in Part I.	231	b. Did tol	bacco use co	ntribute to	the cause of death?
	The law requires that the death certific is the been signed by the attending page 2 should be detached for use as										1 Ye	s 2□No	3 Probe	ably 4 Unknown
3	e ge p	a py								240	Manan	n. dome.	24h Wer	ra autopsy tindings
5	neen houl	e e								298	perform	autopsy led?	avai	ilable prior to
	9 8	ğ											of de	eath?
	ysician: The la is certificate ha director, page	Completed									1 🗆 Ye	s 2X No	10	Yes 2□ No
2	sician: The certificate irector, pag	Be	25. Was casa rat axaminer?	terred to medical					26. Place o	Death (Check	only one	9)		
	yalo	2		□No	Hospital:	ent 2 E	R/Outpatient	3 DOA	Other: 4 Nursi	ing Home 5	Reside	nce 6 20th	er (Specify)	HOSPICE
2	g Phys er this seral di		27. Manner of De		28a. Data of Inju	iry 2	28b. Tima of	28c. In				w injury occur		HOST TOL
5	Ath.	엹	1 Natural 2 Accident	5 Pending investigation		y roar,	Injury		Yes 2 No					
2	after death. Director: After in by the funet	100	3 Suicida	6 Could not b	288. Place of in	ury - At hon	ne, farm, stre	et, factory, offic	9				er or Rural	Routa Number,
5	S Part	Certification:	4 Homicid	6	building, at	c. (Specify)				City	or Town,	, Stata)		
	ours eral		29a. Certifier	197 Certifying Pi	hysician: To the best	of my know	ladaa daath	occurred at the	time date and r	place, and due	to the ce	use(s) and ms	nner as ets	ated
	To the Hoopital or Attending Physician: Tentin 24 hours after deals as a cardiocompiletely filled in by the funeral director, compiletely filled in by the funeral director,	edicai	(Check only one)	2 Medical Exa	miner: On the basis of and manner st	f axamination	on and/or invi	estigation, in my	opinion, death	occurred at the	time, da	ta and place,	and dua to	tha causa(s)
	and and	S .	29b. Signature si	nd the of certifier	and marinor at	atou.		29c Lice	nse number		29	d. Data signe	d (Month, D	lav Year)
	F F 8		/ 1	11:4-					13725	-			11510	
	11/	1 1		100 -				100	13125			2	15 (, 0.
	t IV	1/	30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)											
	111	-		RIQ MAHMO	OD 2300 D	ULANE	VALL.	EY RD.	TIMONI	UM, MD	210	93		
	Stat	_	31. Date filed (M		32. Registr	ar's Signatu	re do	arkal						
	Registra	ar	TED 1	7 2000	LANGE	/								

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State of Maryland / Department of Health and Mental Hygiene 0 4 9 5 5

						,	Cer	tificate o	f Death	,	Reg. No.			
Physiciar		dent's Neme	(First, Middle,	Last)						2. Date of De Month	eeth Dey	Year	3. Time of Death	
/Medica	A	it. Nama (II	Mary	A. Tir					4h City Town o	Februa or Location of Deat			9:40 AM	
Examine												timor		
Funeral		Security No	Living	Sex Coc		ville e (In yrs. las	it birthdey)	If Under 1 Ye	ar If Under 24 H	rs. 8. Dete of Bir				
Funeral Director	219	-18-4	216	1□M 2🌠	-	5	Yrs.	Months Day	s Hours Mi	n. (Month, Pa	** Y 1924		olece (Stete or Foreign ntry) ryland	
pue &	10a. Sta		10b. County			10c. City,	Town or Lo	ation				t	Od. Inside City Limits	
Vany 4 ah	Mary	land	Baltim	ore			Sparks	5					1 ☐ Yes 2 🖾 No	
fer death with the Marylan frems 23s or 28s-f show fret must be nutried at	10e. Str	eet and Num	ber ainflow	er Path	n Uni	t 202		10f. Zip Code 21.	152		10g. Citizen of U.	What Cour		
020 urs at	1 3 3 3 3		ed 2 Merried	Armed 1 1 ☐ Ye	Decedent I Forces? es 2 7 N Give 1	Ever in U,S. No	tf	Ves Decedent of Yes, specify C	f Hispanic Origin? uben, Mexican, Pud o Specify:	(Specify Yes or No arto Rican, etc.)	Bla	14. Race - American Indien, Black, White, etc. Specify: White		
d 21215-0020 filled within 72 hours aff thygiene. ther than "natural; or int, the factor Exer-	Eleme	(Speci	15. Decedent's ly only highest (idery (0-12)	rade complete	ed) e (1-4or 5	i+)		ent's Usuel Occ kind of work dor O NOT use ret	cupation ne during most of w red)	vorking	16b. Kind of B	usiness/Ind		
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land be the dot of the	o 17. Fstn		h L. An	•						lary	Tiep	*		
, Maryland and Should be file saith and Mental Hy azzi is merked other traumatic event	19e. Inf		me/Relationship		(Son)		19b. Mellin	Address (Stre	etend Number or	Rural Route Numb	er, City or Town	, State, Zip 21111	Code)	
D -125	1,0		osition Cremation 3 United Specific Spe		om Stete	cem	efery, crem	ition (Name of etery or other p idge Cer	metery	Date 2-18-00	20c. Location Pikes		wn, State , Marylan	
Baltimor permit. Pages Department of Important: if it any Injury or o	21. Sign	eture of Fun	erel Service Lic	ensee	Rim	Bed		Ruck To	lress of Facility WSON Fune			04		
	23a, Pa	rt1. Enter th	e diseese, or co	mplications th	et caused	the deeth.	Do not ente	r the mode of d	rk Road, lying, such es cerd	iec or respiretory	rrest,	04	Approximate Interval Between	
Physician /Medical Examiner	Immedidisease	ete Cause (F or condition of In deeth)	inel		ONG	ESTIV	É +1	EART	FAILUR				Onset and Deeth HEARS	
Box 68760, saft certificate be associated attending physician and for use as the burial-transit	Cause (that initi resulting	lially list con ading to imi Enter Under Disease or li ated events in death) L	ditions, mediate tying njury	b. H'	ABE	Due to (or a	ioJ s a consequ MEZ	uence of):	TYPE	2				
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The law requires it sate has been signing page 2 should be	Panel Properties	CENA	r in	SUFFIC	ieve	C7					an autopsy ormed?	sv co	ere autopsy findings eilable prior to mpletion of cause death?	
T of the page of	Ę									10	Yes 2 No	1[Yes 2 No	
VITALI I	25. Was	case referre	ed to medicel						26. Place of D	eath (Check only	one)			
Physical Physical Physical Circles Control Circles Control Circles Control Circles Control Circles Cir	10	Yes 2 1	lo	Hospitel: 1	☐ Inpatie	nt 2 EF	VOutpatien	3LI DOA		Home 5□Res	idence 6 Ott	ner (Specil	y)	
		ner of Death Neturel Accident	5 Pending investiget	(A	ete of Injui fonth, Dej	ry y Year) 20	8b. Time of Injury	28c. In V M 1	jury at vork? ☐ Yes 2 ☐ No	28d. Describe	how injury occu	rred		
5 5 6 5 5	3 4	Suicide Homicide	6 Could not determine	288. PI	ece of Injudicing, etc.	ury - At home. (Specify)	e, ferm, stre	et, fectory, offic	8	28f. Location City or To	(Street and Num. wn, State)	ber or Rure	al Route Number,	
Hospi 24 hou Funer day fill	29a. Ce (Ch	eck only	Certifying I	aminer: On th	the best of e basis of nenner ste	examinetion	edge, deeth n and/or inv	occurred at the estigation, in m	time, date and pla y oplnion, deeth oc	ce, and due to the curred et the time,	cause(s) and m dete and plece,	anner as s and due to	tated. the cause(s)	
To the within a faults comple	29b. Sig	Vu	itle of certifier	Elv	21	~		D	3 4 8 2 7		29d. Date signed	od (Month,	Dey, Year)	
11/1/2	JA	MES	ss of parson wh		N)			Print) SLER	DR. SI	JITE 202	- Tows	01	41) 21200	
State	31. Dete	filed (Month	Dey, Year)	32	2. Registre	er's Signetur	0 4	Ina	1/2/					

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THE PARTY OF THE REPORT OF A P. S. the state of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** FEBRUARY 14, 2000 ation of Death 4c. County of Death ELIO TOMASINA 2:20AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL OAK HILL DR. ELDERS BURG If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country)

LTALY 7. Age (In yrs. last birthday) **Funeral** Hours 219-28-4759 1.2M 2□F 79 YIS. Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits CARROLL 1 ☐ Yes 2 No ELDERSBURG Director MA 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò OAK HILL DR. 21784 USA 6120 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Never Married 2 Merried 8 1 Yes 25 No Specify: Specify: WHITE ğ 3. Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hypiene. STEEL FACTORY Elementary/Secondary (0-12) College/(1-4or 5+) 12 STEELWORKER 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Nama (First, Middle, Last) h and Mental F 7 is marked of 8 ROSA CARPANETTI MARIO TOMASINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) of Health of The DR. ELDERSBURG, MD. 21784 HILLIAN SMITH (DAUGHTER) 6120 OAK HILL 20b. Place of Disposition (Nama of cemetery, cremetory or other place) FEB 17 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Removal from State = 5 Department of important: If any injury or LORRAINE PARK CEM. 2000 4 Donation 5 DOther (Specify)-NTon BMENT BALTO, MD. 22. Name and Address of Facility DELLA NOCE & SONS FUNERAL HOME 21. Signature of Funeral Service Licensee 322 S. HICH St. BALTS Med. 2/202 eleplacete Part Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** Motostatu Ademo Cancionia /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Leveral Examiner Pleno Endocene former of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Hypertonsin, Didutes Mellitus, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed this certificate 1 Yes 2 No 1 Yas 2NNo director. 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 20 KNo funeral 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After ! 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29e. Certifier (Check only one)

Attending Division i after death.
I Director: Aft
of in by the fur 6 To the Hospital owithin 24 hours a To the Funeral D completaly State Registrar

filed within 72 hours after

Pages 1 and ≥ should be nent of Health and Mental

Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

21215-0020

Maryland

Baltimore,

ebents, nes 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

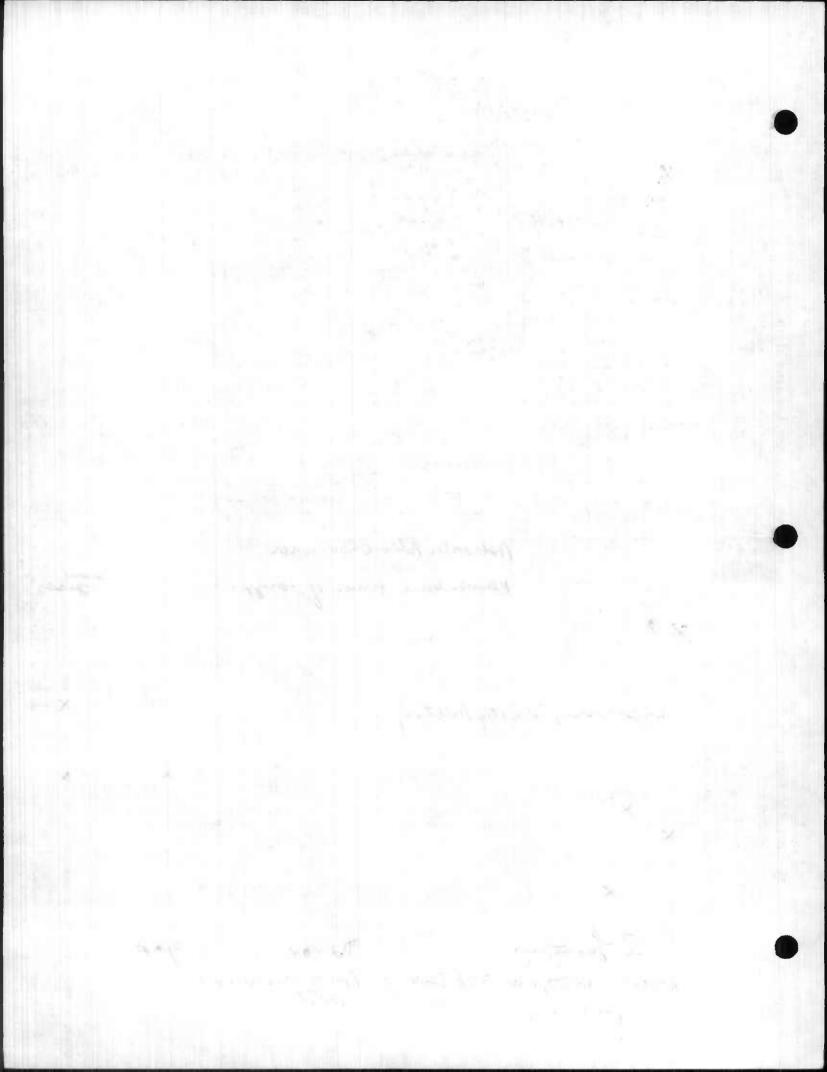
29c. License number 29d. Dete signed (Month, Day, Year) 2/16/00

3508 BANK St. BALTO, Med 21224 ROBERT LIBERTO, MD

31. Dete filed (Month, Day, Year)

29b. Signature and titla of certifier

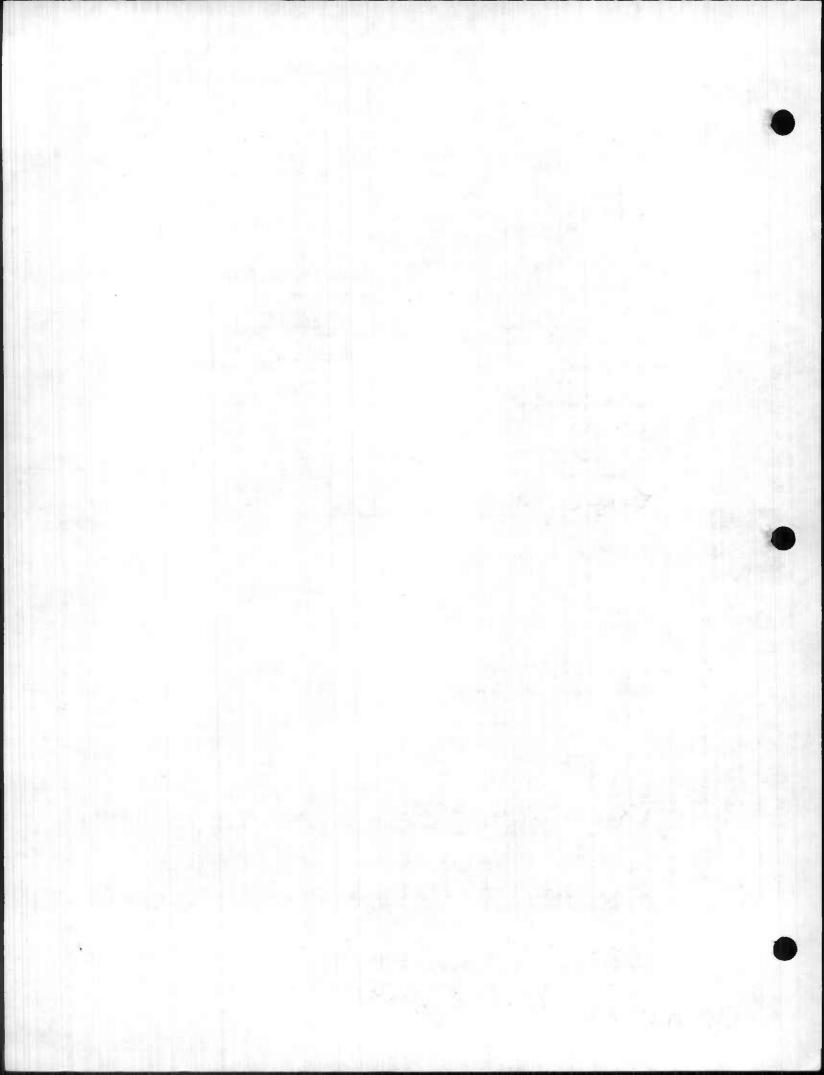
32. Registrar's Signature 2000 FEB17



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State of Maryland / Department of Health and Mental Hygiene 1 4 9 5 7

sician	1. Decedent's Neme (First, Middle, Las					2. Date of Dea Month	Dev	3. Time of De
sician edical		Tutchton				Feb.	15, 2000	
niner	4a Facility Neme (If not institution, give Johns Hopkins Ho				4b. City, Town, or Baltimo	Location of Death TE	4c. County	
ral tor	5. Social Security Number 219-30-5176 6. S	ex 7. Age ☑ M 2□ F	(In yrs. last birtho	Months Day			1934	9. Birthplace (State or Fr Country) Maryland
	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City I
tor	Maryland Baltim	ore	Dunda	lk				1 ☐ Yes 2
eted by Funeral Director	10e. Street and Number 3227 Vulcan Road	1		10f. Zip Code			10g. Citizen of W	
aral				2122		D*-WN-	United	States - American Indian.
by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 Ves 2 No if Yes, Give 1 C Yeer or Detes.	55-1956	 Was Decedent of if Yes, specify Cu Yes 2 No 		rto Rican, etc.)	Blac Specify	k, White, etc.
Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondery (0-12)	lucation	16a. De (G	ecedent's Usual Occi ive kind of work don ie. DO NOT use retir	e during most of wo	orking	16b. Kind of Bu	siness/Industry
S	12 17. Father's Name (First, Middle, Last)		Mech	anical Dra		me (First, Middle,	Bethleh	nem Steel
o Be	John Franklin	Tutchton				rite R. H		-
-	19e. Informant's Neme/Relationship (1		19b. N	eiling Address (Stree				State, Zip Code)
	Clyda N. Tutchto	n/ Wife	322	7 Vulcan F	Road Dund	alk. MD	21222	
	20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removel Irom Stete	cemetery,	crematory or other pi	ece)			City or Town, State
	4 □ Donation 5 □ Other (Specify	1)	Chesape			2/17/200	O Belts	sville, MD
	21. Signature of Funeral Service Licen	11 1		CAFA Step 8717 Gree	phen D. L	ohrmann 1	P.A.	
	23a. Part 1. Enter the disease, or comp	Natice dealy	he death. Do not					Approximate
	shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure. List only of the lailure is shock, or heart lailure is shock, or	one cause on each line	.					Interval Between Onset and Dee
	resulting in deeth)		oue to (or es e cor	sequence of):			100	Days
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Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		oue to (or as a cor	sequence of): Hemmorhas	20			/ T71
edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	ue to (or as a con		3e			4 Weeks
Physician/M		d						
Physi	Part II. Other algoriticant conditions or Renal Failur		not resulting in th	e underlying cause g	iven in Pert I.		obacco use cor /as 2□ No	atributs to the cause of d 3☐ Probably 4⊠Un
Completed by						24a. Was a	an autopsy med?	24b. Were autopsy find available prior to completion of cause of death?
omp						101	es 20 No	1 Yes 2 No
BeC	25. Was case referred to medical examiner?				26. Place of De	eath (Check only o	ne)	
	1 ☐ Yes 2 No	Hospital: 1 Inpatien		ment 3LI DOA		Home 5 ☐ Resid		
2	27. Menner of Deeth 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim Inju	ry W	ury at ork? ☐ Yes 2 ☐ No	28d. Describe h		
-	2 Accident investigation			street, fectory, office	9	28f. Location (S City or Tow		er or Rural Route Number
Certification: T	10.00 -01 - 01 - 0	28e. Placa of fnjur building, etc.	y - At home, farm (Specify)					
Certification: T	2 Accident 3 Suicide 4 Homicide 29e. Certifier 2 Certifying Physics	building, etc.	(Specify) my knowledge, dexamination and/o	eath occurred at the	time, date and place opinion, deeth occ	e, and due to the curred at the time, o	ause(s) and ma	nner as stated. and due to the cause(s)
-	2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only 2 Medical Exam	yatctan: To the best of inner: On the basis of a and manner state	(Specify) my knowledge, dexamination and/oed.	eath occurred at the r investigation, in my	opinion, deeth occ	urred at the time, o	cause(s) and ma date and place, a 29d. Date signed	anner as stated. and due to the cause(s) d (Month, Day, Year) my 15, 2000 t. Baltimore W



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of the OYCE m. UMStead 2:00 Am 2000 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Bon Secours Hospital N/ABaltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Min. March 8,1946 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Months Deys 214-50-7158 53 Yrs Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits TY Yes 2 No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 339 S. Bentalou Street 21223 United States 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ◯ No Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education fy only highest grade completed) 16b. Kind of Business/Industry (Specify o Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Samue1 J. Imbrogulio Rache1 Revnolds 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2825 Florida Avenue Garrison A. Umstead/ Son Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/17/00 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Hubbard Funeral Home, Inc. Homas 文 Manuta 4107 Wilkens Avenue Baltimore, Maryland 21229 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of): ENcophalopathy Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last myocardial Subendocard Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) inpatient 2 ER/Outpatient 3 DOA 27. Manper of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Naturaí 2 Accident 5 Pending 1 Yes 2 No investigation 3 Sulcide 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner as steted.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division of Vital Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this cartifice attaly filled in by the funeral director. To the Hospital within 24 hours of To the Funeral Completaly filled

> State Registrar

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

the Maryland

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other traumatic event, he Mexical Examiner must be notified a once.

Physician /Medical

Examiner

physician end the burial-trensit

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The lew requires that the death cartificate be executed

Records, P.O. Box 68760.

Examiner

Physician/Medical

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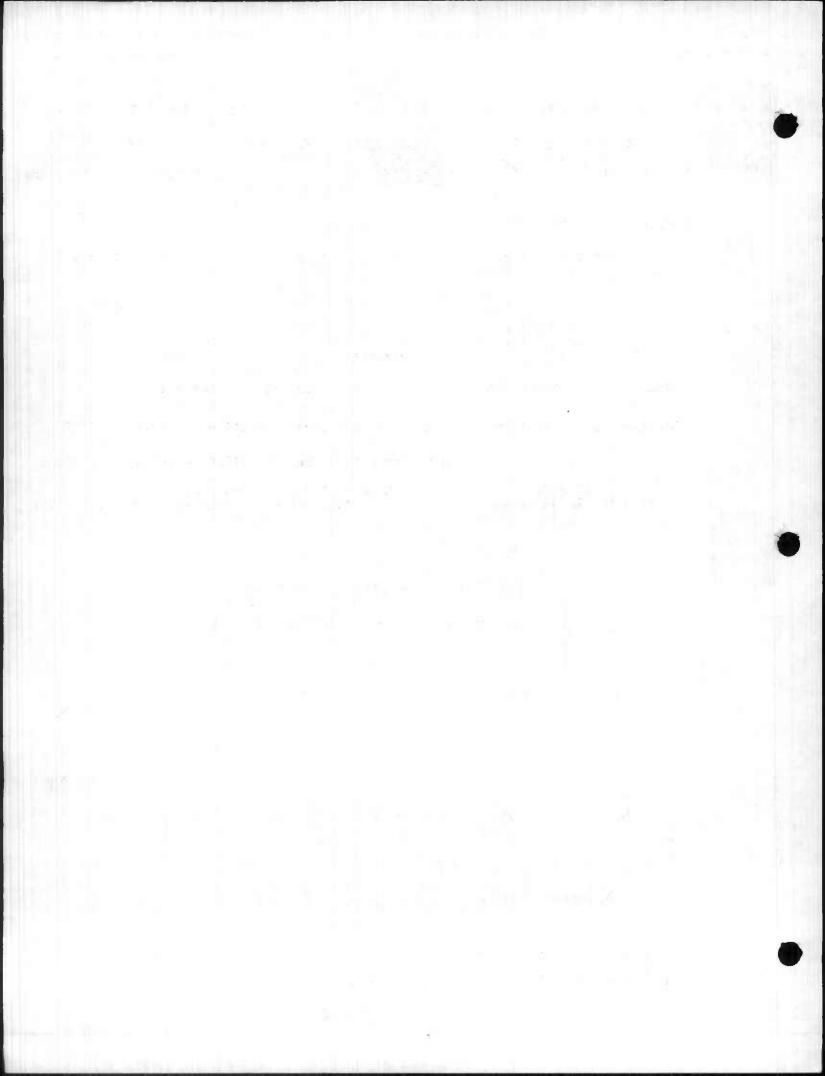
Baltimore, Maryland 21215-0020

31. Date filed (Month, Dey, Yeer)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 32. Registrer's Signature Benevas

Hospitel Baltimore

DHMH 16 Rav 6/95



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	21. Signature of F	-uneral service L	D	V,			ns Falls				
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	shock, or he	eart failure. List o	only one cause or	ach line!							val Between et and Death
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	resulting in death	1)		Due to (r as a consequ	ence of):				1	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, AMEND#1 PER MD. G780 2-22-2000 JAB State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death BEUREN Month Year **Physician** Michael Bryant FEB15 2000 12:05 PM van Beuran /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 10913 Park Heights Avenue | Owings | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Mills Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1□ M 2□ F Director JULY 6, 1942 150-32-8732 New Jersey 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No MD Baltimore Owings Mills Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10913 Park Heights Avenue 21117 USA Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) TYPAS 2 No 1963/ 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1967 Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 5 +Self-employed Contractor 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be in ment of Health and Mental H tant: If them 27 is marked off jury or other trausmalic even å John van Beuren Jane de Peyster 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Anne Francis/daughter 201 St. Botolph St., Boston, MA 02115 20b. Plece of Disposition (Nama of cemetary, crematory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/16/00 Baltimore, MD 21. Signature of Funaral Servide Licensee Cremation Society of Maryland, Inc. nomor Thomas Gregot 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heer feilura. List only ona causa on aach lina. Approximeta Interval Between Onset and Death **Physician** /Medical YEARS 3 MONTE Immediete Causa (Finel disaasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner bunal-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseasa or Injury that Initiated evants resulting in death) Last Dua to (or as a consequence of): Physician/Medical the Due to (or as a consequence of) 82 950 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown þ Be Completed page 2 Medical Certification: To filled in by

The law requires that the death certificate be executed Box 68760 O Division of Vital Records. or Attending Physician:

the Manyand

filed within 72 hours after

altimore, Maryland 21215-0020

23a or

Herman

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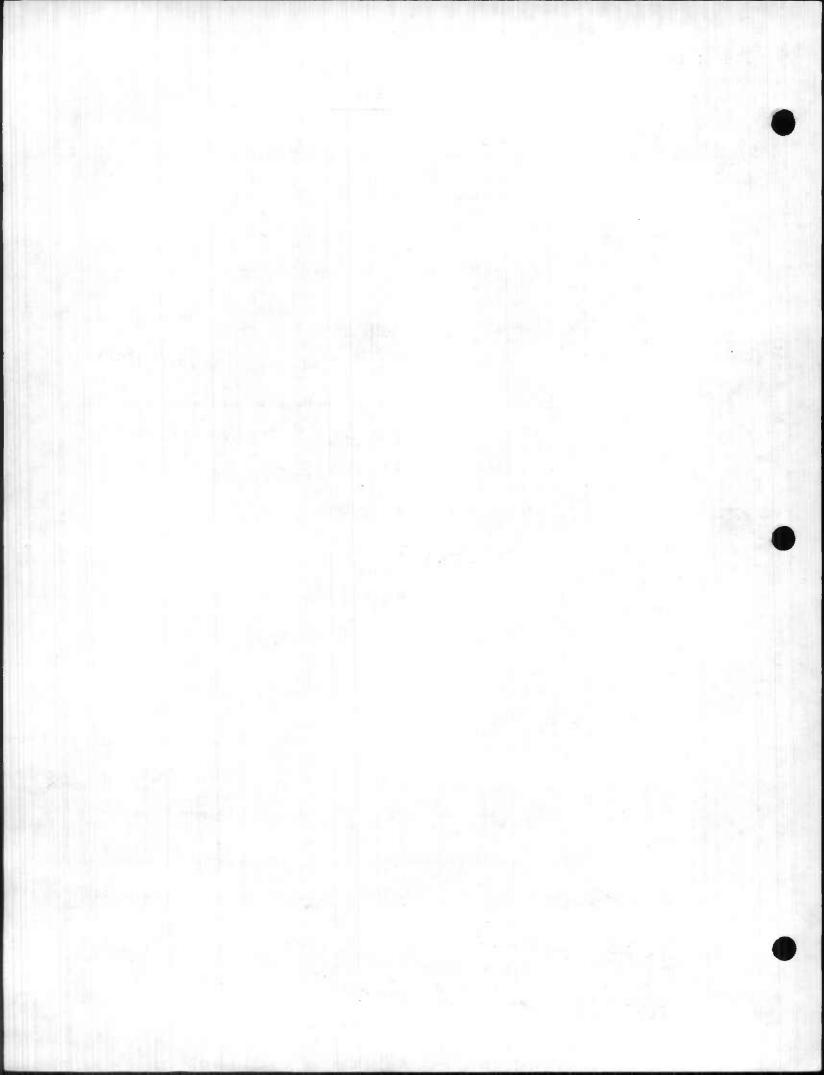
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29e. Certifier (Check only one) Certifying Ph. 2 Medical Example (Check only one)	ysician: To the best of my kno ilner: On the basis of examine and mannar stated.	owledge, death o ation end/or inve	occurred at stigation, in	the time, date and place my opinion, death occ	ce, end due to the cause(s) end m curred at tha tima, data and plece,	nenner as stated. , end due to tha cause(s)
29b. Signature and title of certifier	4		29c. t	icense number 29373	29d. Data signo	ed (Month, Day, Year)

State Registrar

24 hours after death.

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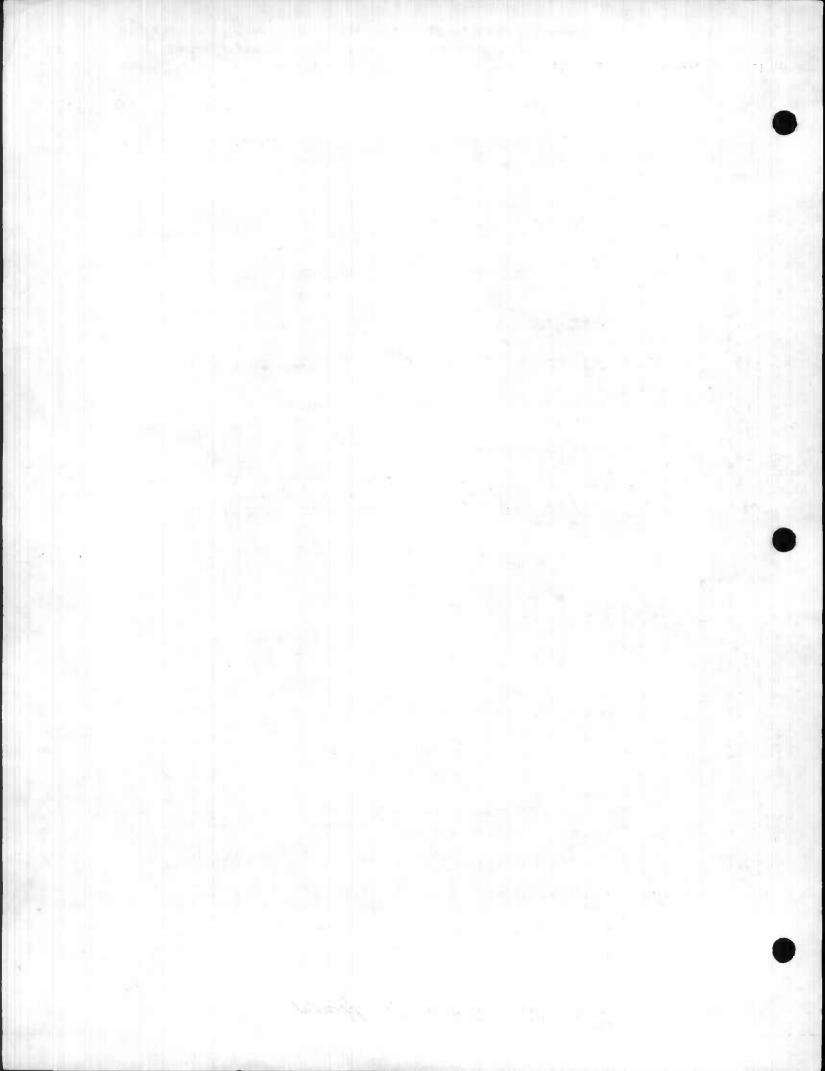
Hospital



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Direc In by	27. Manner of D 1 Matural 2 Accider 3 Suicide 4 Homici		200. FINUS UI	Injury - At hi , etc. (Specil	y)	et, tactory, office	,	City or To	(Street and Numb wn, State)	or mural Houle	rvuntiber,
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8		Veen	/				21217		JANUARY	727, 20	00
28	30. Name and a	ddress of person wh	o completed cause	of death (Iten	n 23a) (Type, P		21217		JANUAKI	27, 20	00
To the Hospital or Attends Within 24 hours after death. To the Funerel Director: A completely filled in by the fu	DR 76		m.D.		BURG F	rint)		26, M			00

Registrar DHMH 16 Rav 6/95

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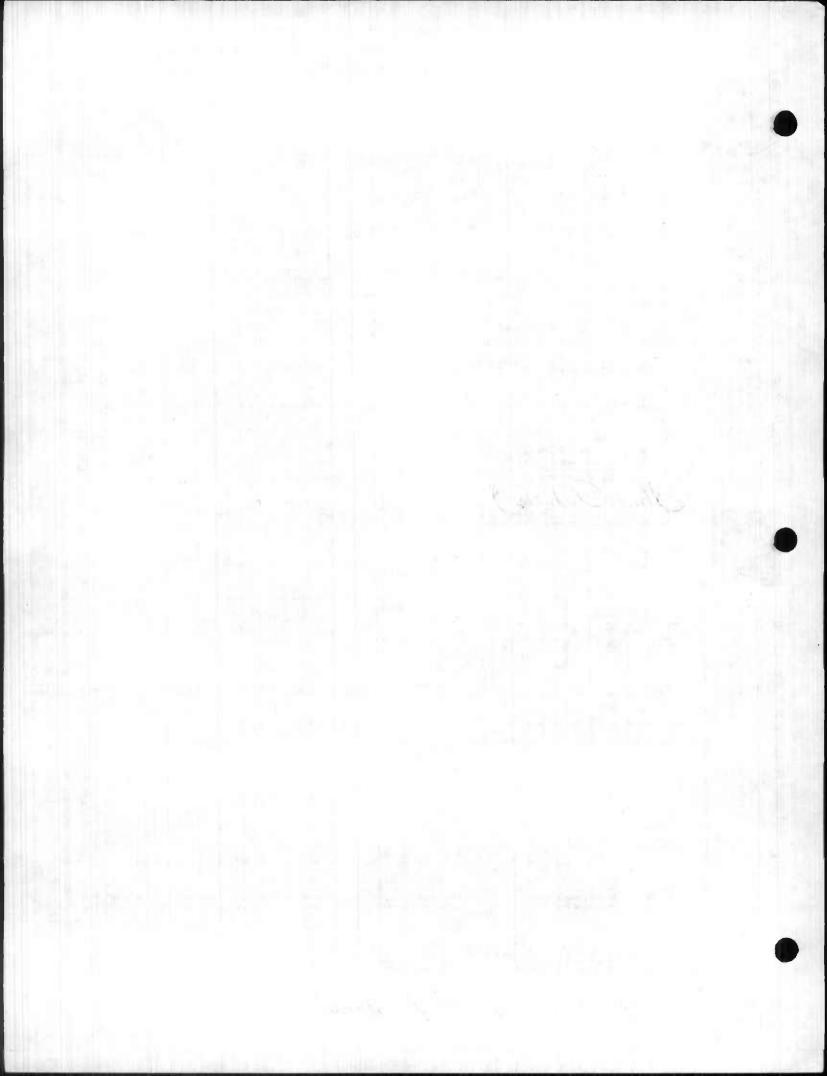
Piease Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Dev **Physician** James Russell Waddill 15,2000 January 10:14 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year 8. Date of Birth (Month, Day, Year) July 24,1918 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1₽M 2□ F 81 Yrs Ringold, VA 224-05-7838 Director Usual Residence of Deceden the Maryland 10e Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 8how 1 Yes 2 □ No Director Washington D.C. 280-1 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or flams 23s or U.S.A. 20011 422 Jefferson Street, N.W. Funeral 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, Whita, etc. 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Merried Specify: Black altimore, Maryland 21215-0020 1 Yes 2 No Specify: 7 3 Widowed 4 Divorced Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker U.S.Govt. permit. Papes 1 and 2 should be filled with Department of Health and Mental Hygien Important: If New 27 is marked other than any Injury or other traumatic avenue. 12TH 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Lucille Thomas Elmer Waddill 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Vivian G. Waddill/wife 422 Jefferson St., NW, Wash., DC 20011 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 1/22/00 Bladensburg, MD 4 Donation 5 Other (Specify) FT. Lincoln Cemetery 22. Name end Address of Fecility Latney's Funeral Home 21. Signature of Euneral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feliure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Final a Acute Dyocardial Infarction disease or condition resulting in death) Examiner Prostate Carles consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Metastatic Cancer Box 68760, Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? P.O. 2 to Yea 2 No 3 Probably 4 Unknown signed b Records, à 24b. Were autopsy findings available prior to 24e. Was an eutopsy performed? Completed completion of cause of death? 1 Yes 2 BNO 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Dete of fnjury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending death. 1 Tyes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0034526 30. Nama and address of person pleted cause of death (Item 23a) (Type, Print) Hospital Drive State

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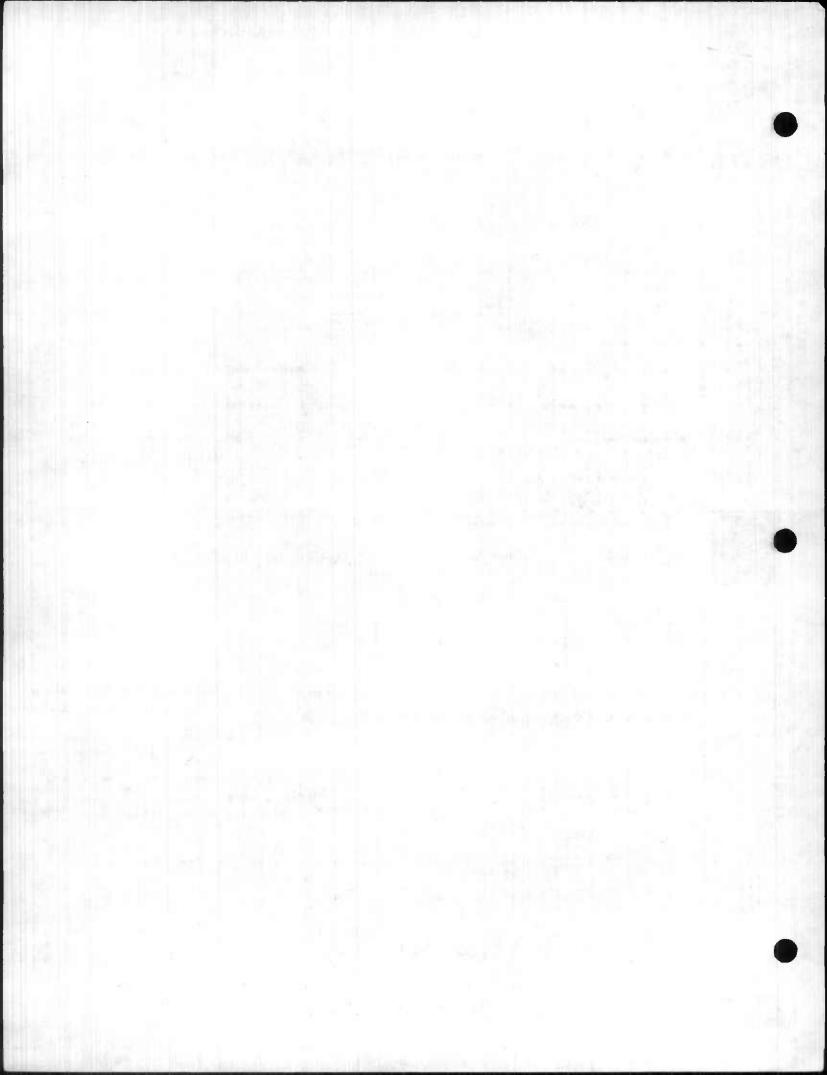
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ate of Maryland / Department of Health and Mental Hygiene	04	98	53	
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SRT	WILSON			Cert	ificate of	Death	Re	eg. No.	
		1. Decedent's Name (First, Middle, La	st)				2. Date of Deat		3. Time of Death
	Physician	Robert Gage W:	ilson, Jr.				FEBRUAR	200	0 10:27 P.M.
	/Medical Examiner	4a Facility Name (If not institution, give				4b. City, Town, or La		4c. County of De	
	Funeral Director	2800 BALTIMORE AV. 5. Social Security Number 6. 5 123–10–7236		. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		ER inthplace (State or Foreign Country) Wash. D.C.
	2	Usual Residence of Decedent	140.0						Transition and the second
	death with the Maryland me 23s or 28s-f show Emist be notified at mera! Director	VA N/A		ity, Town or Loca rlingto					10d. Inside City Limits 1 Yes 2 No
	her death with the Mar r flerm 23s or 28s-f al siner must be notified funeral Director	10e. Street and Number 4520 North Ditt	mar Road		10f. Zip Code 222	07	10	0g. Citizen of What 0	Country?
21215-0020	urs after Mr, or its by Fur	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:		as Decedent of Yes, specify Cut Yes 2 X No	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
5-0	ed within 72 hours yglene. Ar than 'natural', A, the Median Completed by	15. Decedent's E	ducation de completed)	16a. Decede	nt's Usual Occu	pation during most of work	ina	16b. Kind of Busines	s/Industry
21	n non	Elementary/Secondary (0-12)	College (1-4or 5+)	life. Do	O NOT use retin	od)			
		12	2	Bro	ker	T		Yacht Sale	es
Maryland	should be filed and Mentel Hyginarked other imate avent, To Be Cc	17. Father's Name (First, Middle, Last				18. Mother's Nam		Maiden Surname)	
YIE	ahouid be and Mentel marked o umartic av						oker		
Aar	2 sho	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Stree	t and Number or Rur	al Route Number,	, City or Town, State	, Zip Code)
	1 and Health em 27 ther tr	Judy Brown/Nieco			unwoody	Drive		ville, So	
010		20a. Method of Disposition 1 \$\overline{\Omega}\$ Burial 2 \$\overline{\Omega}\$ Cremation 3 \$\overline{\Omega}\$		Place of Disposi cometery, crema	ition (Name of story or other pla	ice)	Date	20c. Location - City of	or Town, State
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Baltimore,	permit. Page Department Important: If eny Injury or pncs.	21. Skynature of Funeral Secure Lice	ing)	22.	Name and Addr	ess of Facility			
x 68760,	be a by the attending physician and deteched for use of the buriefransit deteched for use of the buriefransit deteched for use of the buriefransit by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence or as	ence of):	Scupa	DISEDJĖ		
Box	thet the death ce by the stendi deteched for use Physiciary	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the und	derlying cause g	iven in Part I.	23b. Did to	bacco use contribu	Ite to the cause of death?
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Records,	aw requir te been a 2 should pieted							med?	b. Were autopsy findings available prior to completion of cause of death?
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of Vital	Physician: this certificant director,	25. Was case referred to medical examiner?	Hospital:			26. Place of Deal			CCENE
	2 2 2	1 Yes 2 No 27. Manner of Death 1 Destural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 LI Nuising Ho		once 8 Nother (Sp ow injury occurred	pecify) SCEINE
Division	or Attendent Strector: in by the	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined				***	281. Location (St. City or Town		Rural Route Number,
	D 24 hound he Funer plately till edical		yaician: To the best of my known of the basis of examination and manner stated.						
	To the sound	29b. Signature and title of certifier	hall so	N.o.	29c. Licen	se number	25	9d. Date signed (Mo	nth, Day, Year)
	10,1/2,	30. Hame and address of person who	completed cause of death //to	m 23a) (Type Pr	O.C.	M.E.	F	EBRUARY 1	1, 2000
	11/2/	31. Date fled (Month, Day, Year).	32. Regisfrar's Sign	1		Street,	Baltimor	e, Maryla	nd 21201
	State Registrar	7. 317	2000 Service	19	Spar	Ks			



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** February 12, 2000 Anna Barbara Williams 6:30 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10M XOF Months Yrs. 217-12-6547 93 Director June 18, 1906 Maryland Usual Residence of Decedent the Maryland 10a State 10h County 10c City Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23s or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7600 Clays Lane 21207 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after of Hygiene. 1 ☐ Never Merried 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: à 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Itam 27 is marked other any Injury or other traumado event, page. 18. Mother's Name (First, Middle, Maiden Sumeme) William Douglas Leitch Anna Barbara Voss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Gloria Connor - Daughter 1164 Linden Avenue; Baltimore, Maryland 21227-2335 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 2/16/2000 Woodlawn, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 M00869 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (gras a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. w Physician/Medical Due to (or as a consequence of): 80 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 1 Yes 1 ☐ Yes 2 ☐ No 2 0 No certificate Division of Vital 25. Was case referred to medicel examiner? 8 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2D No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt.
within 24 hours after death.
To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Tima of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Cea completed cause of death (Item 23a) (Type, Print) 30. Name and address of person will arre sveme

State Registrar 31. Date filed (Month, Day, Year)

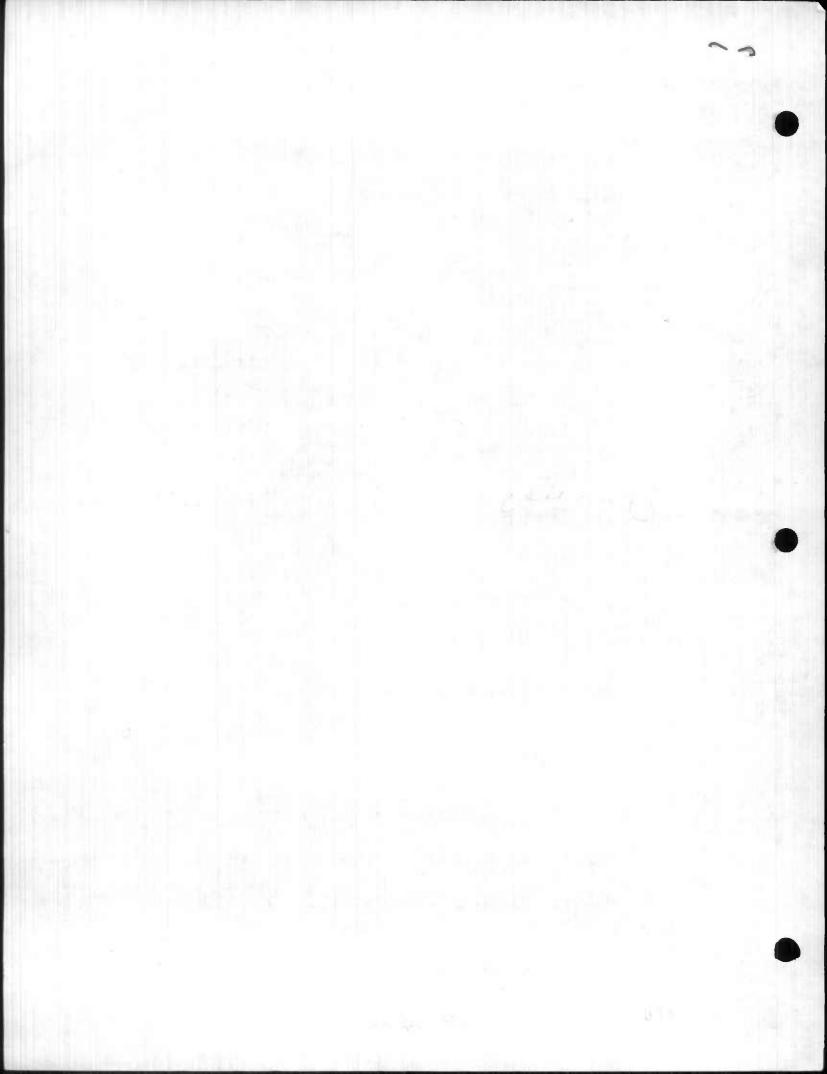
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32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Year 14,2000 4c. County of Death 4a Fecility Name (If not institution, give straet and number) Constance Weinhold 1d Feb. 4b. City, Town, or Location of Death 7:45am G.E.C. Hammonds Lane Brooklyn Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dale of Birth (Month, Day, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 10 F Months 213-01-6215 79 Yrs. MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Rosedale 1 ☐ Yes ≱☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7612 Brightside Ave. 21237 USA 12. Was Decedeni Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Wes Decedeni of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Irvington Fed. Bank 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surnama) Vernon Schmidt Marion Plum 19b. Malling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Gloria Cullison / sister P.O.Box 4322 Estes Park, CO 20b. Placa of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Heart of Jesus 2-18-00 Dundalk, MD 21. Signature of Puneral Servica Licensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTENSIVE ALTERIOSCIBRUTIC CARDIO 3 46AV9 disease or condition resulting in death) VASCULAR DUSEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIABETES 24b. Were autopsy findings available prior to 24a. Was an autopsy METABOLIC ENCEPHALOPATHY completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury ai Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, Division of Vital Records, P.O.

instance Wenhold

State Registrar

Physician

Funeral

Director

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nit. Pages 1 end 2 should be filed within 72 hours efter carment of Health end Mentel thygiene. ortant: If them 27 is marked other than "natural", or file in linuy or other traumatic avent, the Medital Emerical injury or other traumatic avent, the Medital

Department of Important: If any Injury or

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Baltimore, Maryland 21215-0020

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/Medical Examiner

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Certification:

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Yaar)

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



SUMAP. MUNORA MO 8109 RITCHIE KWY PASADEND MARYLAND

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

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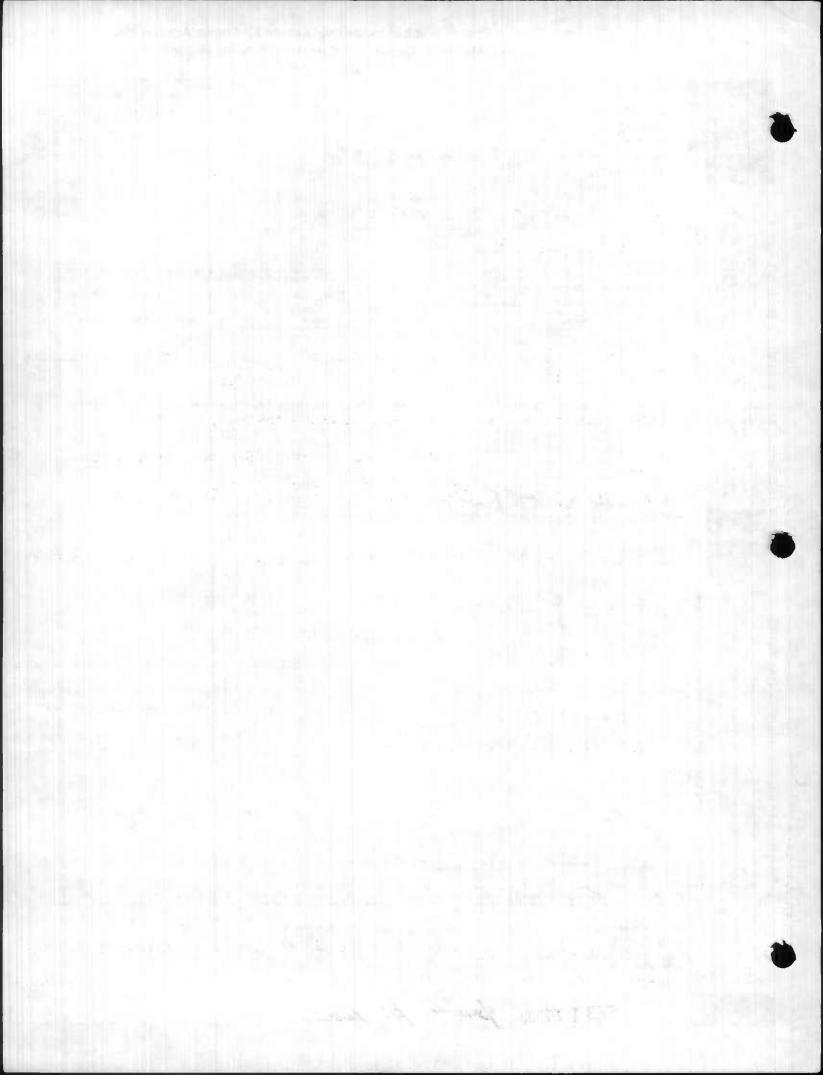
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29d. Date signed (Month, Day, Year)

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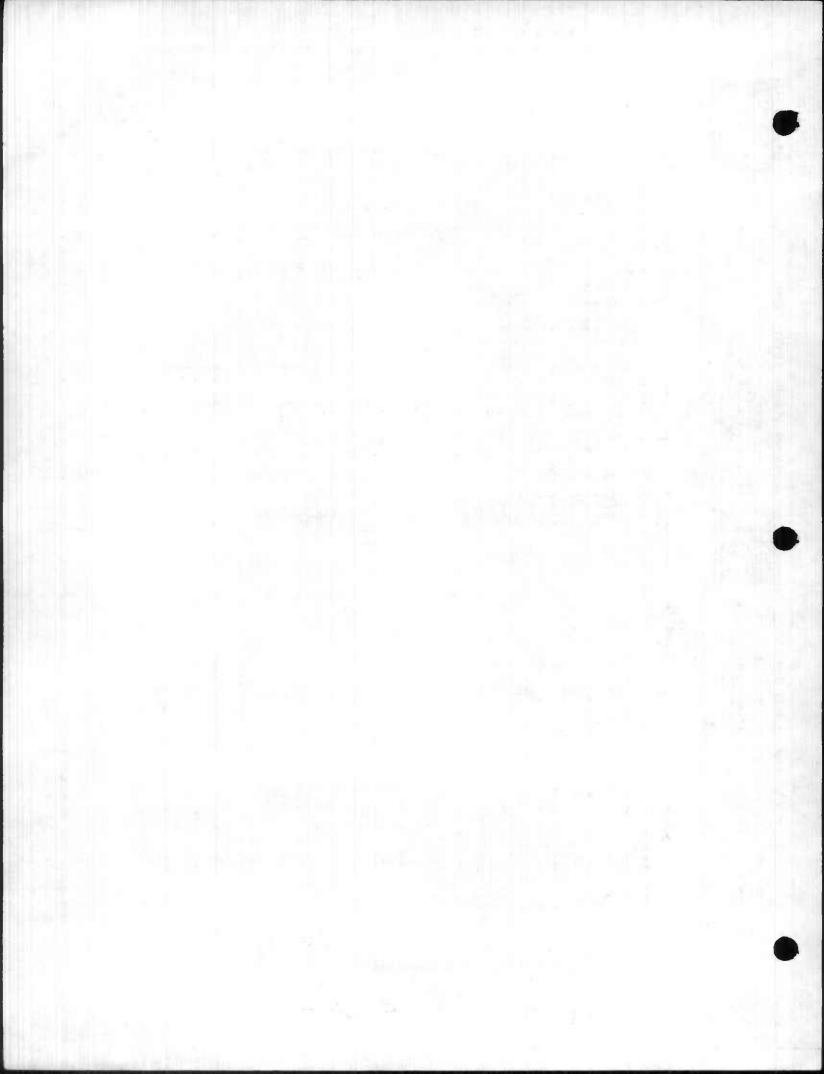
PEBRUARY 15

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth Williams Month **Physician** 3:30AM 6150 10 2000 February /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical Center University Baltimore If Undar 24 Hrs. If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Hours 1 M 2 XX 39 Months 218-84-6289 Director Sept. 13, 1960 Md. Usual Rasidence of Decedant death with the Maryland 10b. County 10a. Stata 10c. City, Town or Location r than "natural", or hams 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits Md. n/a Baltimore 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 3306 N. Hilton Street 10g. Citizen of What Country? 21216 USA Apt. 301 Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Maritel Status Bleck, Whita, atc filed within 72 hours after 1 Never Marriad 20 Merried 1 Yes 2 XX Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: If Yas, Giva Yaar or Dates: Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry ith and Mentel Hygiene.
27 Is marked other than "r traumatic avant, pre Men Elementery/Secondary (0-12) College (1-4or 5+) Mercy Hospital Pharmacy Technician 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mentel I ant: If Itam 27 is marked of Leonard Jones Annette Alexander 19a. Informant's Name/Relationship (Type, Print)
Gregory Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3306 N. HIlton Street Apt. 301 Baltimore, Md. 21216 Husband or other 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, State 2☐ Burial 2 ☐ Crametion 3 ☐ Ramoval from State permit. Page Department of Important: If any Injury or pace. Md. National Cemetery Feb. 16 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura of Funaral Sarvice Ligensee 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on a similar than the cause of the caus Intarval Batween Onset and Deeth **Physician** Concer /Medical Immediate Cause (Final disaasa or condition rasulting in death) Examiner Examiner sician and bunal-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaase or Injury that initiated events resulting In death) Last Dua to (or as a consequence ot) physician s the burial Box 68760, Physician/Medical Due to (or as a consequence of) 88 .030 P.O. signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Ware autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 certificate 1 Yas Division of Vital or Attanding Physician: funeral director, Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No this 28d. Dascribe how injury occurred 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 5 Pending invastigation 1 Natural 24 hours after death. 1 Yes 2 No 2 Accident 6 Could not be detarmined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At homa, ferm, street, tectory, office building, atc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medicat Examiner: On the basis of axamination and/or invastigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end mannar stated. 29a. Cartifie completely (Check only one) To the I within 2 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signatura end title of certifie February 10, 2000 30. Nama and addrass, ot person who completed causa of daath (Item 23a) (Type, Print) Boltimore, MD 21201 South Greene 31. Date tiled (Month, Day, Year) 32. Registrar's Signetura State 2000 Gaper Registrar

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WILLIAMS, PATRICIA

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	Physician /Medical	PATRICIA ANN	WILLIAM	IS					BRUARY	15,	2000	4:30 A.
	Examiner	4e Fscility Name (If not institution						wn, or Location	of Death	4c. County		
		GREATER BALL						WSON		BALT.		
	Funeral Director	5. Social Security Number 21.2-78-2260	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. le 39	Yrs.	Months Days	If Under :	Min. (A	ate of Birth fonth, Day, Ye -03-61	0	Countr	ce (State or Foreign Y) IMORE
	D	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					100	d. Inside City Limits
	Varyt tahe leda	MD N/A		BAL	TIMO	RE						1X Yes 2 No
	or 28a-f s to 28a-f s be notified Director	10e. Street and Number	-			10f. Zip Code			10g.	Citizen of V	/hat Countr	y?
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<u>a</u>	ficate or. pa	25. Was case referred to medical					20.51	15 11 101	1 🗆 Yes	21/2 No	10	Yes 2 No
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á.	tal or Attending Pins after death. al Director: After the index in by the funera Certification:	4 Homicide	buildin	ig, etc. (Specify)	,			6	ity or Town, S	ilate)		
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	29e. Certifier	Physician: To the kaminer; On the ba	best of my land	fedge, death	occurred at the ti	me, date and	d place, and de	ue to the caus	e(s) and ma	nner as sta	ted.
	in 24 hours in 24 hours he Funer pletely fill edical	one)	and mann	or stoled.	A TO	restigation, in my	opinion, deal	in occurred at	trie time, date	and place, a	and due to t	ne cause(s)
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altimore, Maryland 21215-0020

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene CALVIN D. YOUNKERS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Calvin Dennis Younker FEBRUARY 9, 2000 1633 PM /Medica 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death WASHINGTON Examiner HAGERSTOWN WASHINGTON COUNTY HOSPITAL Min. Bate of Birth (Month, Day, Year)

September 22,1954 If Under 1 Year T 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days 1 M M 2 □ F MD Yrs. 219-66-0377 45 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director PA Fulton Warfordsburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 465 Harmonia Road Funeral 17267 USA 12. Was Decedent Ever in U,S. Amped Forces? 1 M Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. ğ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Road .12 Construction Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be LeRoy Divelbliss Janet Younker 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine M. Younker/Wife 465 Harmonia Road Warfordsburg, PA 17267 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2/13/2000 Smithsburg, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility
Grove Funeral Home, P.A. 141 W.Main St. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Due to (or as a cons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 No 1 Yes 1 Pes 2 No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient ②□□• Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner physician and the burial-transit that the death certificate be executed Box 68760. 88 2 signed b Records, page 2 certificate director

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of Vital

Division Attending

/Medical

Certification: To

Medical

XX Yes 2□ No

29a. Certifier

(Check only one)

29b. Signature and title of certifier

27. Menner of Death

1 Natural 5 Panding Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

FEB 1

28a. Date of injury (Month, Day Year) 9/00 Plane of triury - At home, farm, street, factory, office building sic. (Specify)

28b. Time of 3PM

28c. Injury at Work? 1 Yes 2 No

29c. License number

28d. Describe how injury accurred to the Collides with or vehicle mot fixed object with 281. Location (Street and Number or Rural Route Number City or Tewb, State)

Ridge Road street Hancoc 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

O.C.M.E.

ated cause of death (Item 23a) (Type, Print) 30. Nam

29d. Date signed (Month, Day, Year) FEBRUARY 10, 2000

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State Registrar

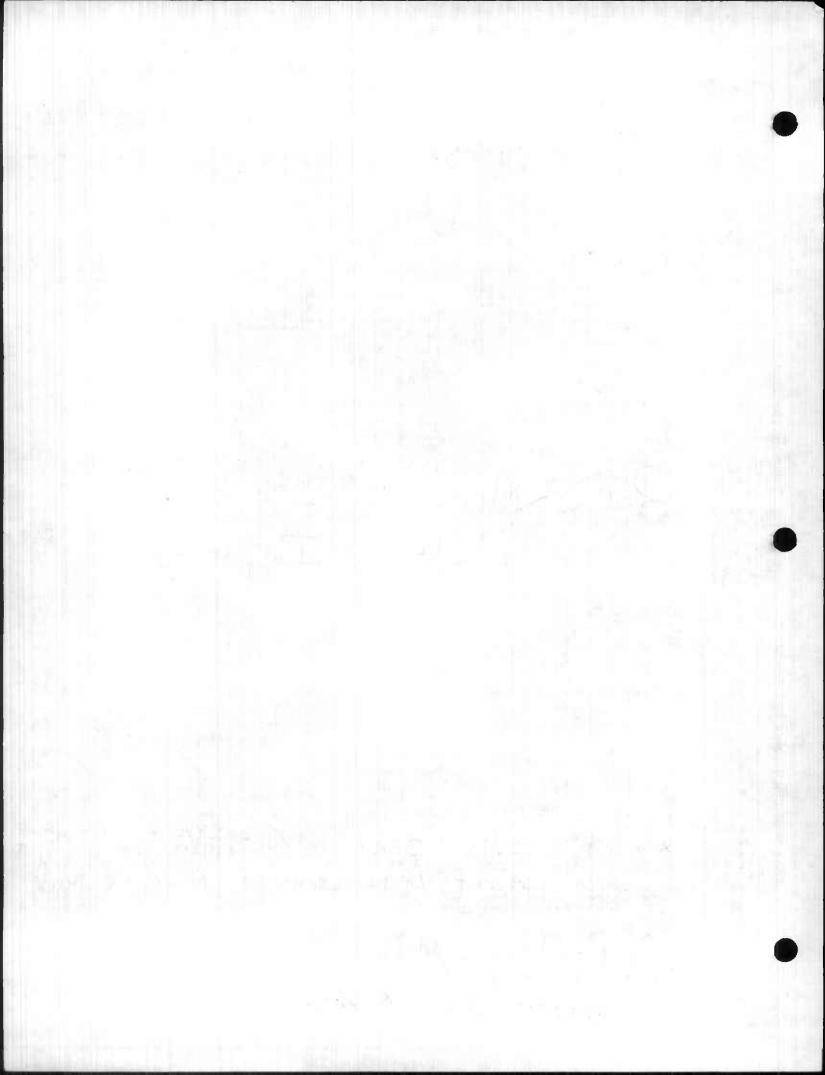
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗌 🗍 AMEND20b PER F.H. G780 2-17-2000 JAB Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Month** Year **Physician** aisa 2 2 Eawi JZ trof zury 2000 /Medical 4c. County of Death 4a Fecility Neme (if not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Yaer If Under 24 Hrs. 5. Sociel Sacurity Number 6. Data of Birth Month, Day, Year) MAY 15 1961 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Months Davs Hours USA Country 1□ M 2₩ F 219-92-3091 38 Yrs. Director **Usual Residence of Decedent** the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director MD CARROLL **ELDERSBURG** 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1343 WALKABOUT COURT 21784 USA Funeral Berra: 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Stetus Black, Whita, atc. Hygiene. ther than "natural", or ther ent, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after red of Health and Mental Hygiene.

ett if tiem 27 is merked other than "natural", or the sity of other traumels event, the Medical Examine any or other traumels event, the Medical Examine 1 Nevar Married 2 Married 1 ☐ Yas 2X No Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: YAS GIVE Specify:WHITE þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be IZRAEL MINKEROV ALISA AKKERMAN 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1343 WALKABOUT COURT ELDERSBURG, MD.21784 EMANUEL ZAMIR/HUSBAND 20b. Place of Disposition (Nama of Language Crematory or other place) BERTY CON CONG. PARK 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 □ Crametion 3 □ Ramoval from Stata 4 Donation 5 Othar (Specify) 2/16/2000 RANDALLSTOWN, MD. 21. Signature of Fynaral Solvice Licepeda 22. Neme end Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intarvat Between Onset and Death Physician tmmediate Cause (Finel disease or condition rasulting in daath) /Medical Sitorg Examiner Due to (or as a consequence ot) Examiner The law requires that the death certificate be executed ician and bunal-trans Sequentially list conditions, if any, leading to immadiate causa. Entar Undarfying Cause (Disease or Injury that Initiated events rasulting In death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the Dua to (or as a consequence of): 82 USe P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? be detached 3 Probably 4 Unknown 1 | Yes 2 | No of Vital Records. Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐ Yas 2 000 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa rafarred to medical examinar? Certification: To Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NZ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Day Year) funaral 27. Mannar of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After ! Division 5 Panding Invastigation 1 Natural within 24 hours after death. To the Funeral Director: A 2 Accidant 1 Yas 2 No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Placa of Injury - At home, farm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide Hospital 15 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mannar as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical completaly (Check only one) To the 29b. Signatura and titla of certifian 29c. License number 29d, Data signed (Month, Dav. Year)

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State Registrar 31. Dete filed //

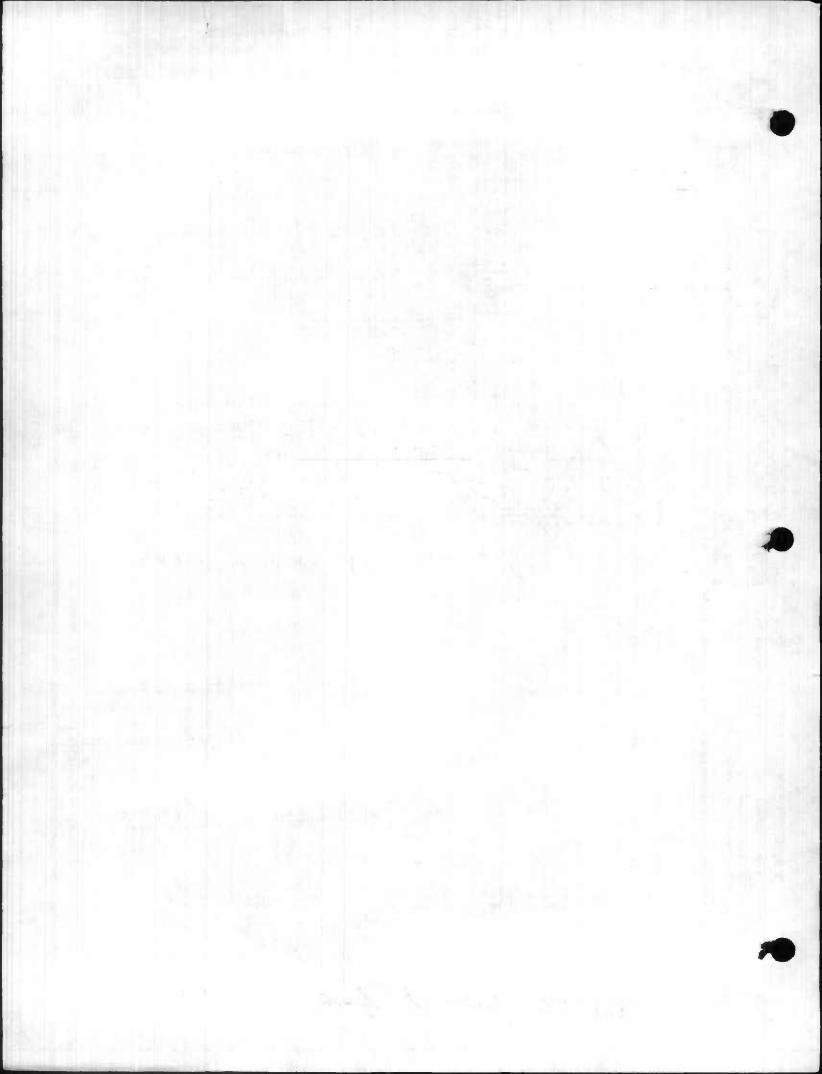
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32. Registrar's Signature

Mossita

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month BARNES MABLE FEBRUARY 8.35 Pm 14 2000 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death to vrs. last birthday fit Under 1 Year Months Days 4c. County of Death BALTIMORE r If Under 24 Hrs. 8. Data GOOD SAMARITAN BALTIMORE (5. Social Security Number 8. Data of Birth (Month, Day, Yaar) 9-19-16 Birthplace (Stata or Foreign Country) 1□ M 2 1 F Min Hours 201-07-2780 PA. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Q Yes 2 □ No MD. N/A BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2406 E. OLIVER ST. 21213 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - American indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yas, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: BLACK Specify 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilega (1-4or 5+) -12--0-CUSTODIAN GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) DANIEL COX **EVELYN THOMAS** 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4540 THE STRAND BALTIMORE, MARYLAND 21215 CLARENCE COX(SON) 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST VETERANS 2-22-2000 OWINGS MILLS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 1ac a 23a. Part . Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipk, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death immediete Ceuse (Finei SEPSIS disaase or condition resulting in death) 4 DAYS Due to (or as a consequenca of) PNEUMONUA Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) thet initiated events resulting in death) Last Due to (or as a consequence of): Part fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIUS PHYMONARY DISCASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CORONARY ARTERY DISEASE DIABETES 1 ☐ Yas 1 ☐ Yes 2 No 26. Piaca of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of injury (Month, Day Yaar) 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred 5 Pending 1 Yes 2 No

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To the Funeral Director: Afte completely filled in by the fun

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or itema 23a or traumatic event, the Mexical Examiner must be r

2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "nature!", or item

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m any injury or other traum once.

Physician /Medical

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Certification:

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29a, Certifier

Baltimore, Maryland 21215-0020

the Marylend r 28a-f show a notified at

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death

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide

25. Was case referred to medical axaminer?

4 - Homicide

investigation 6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, Stata)

29b. Signature and title of certifier doloo

29c. License number P12557

29d. Data signed (Month, Day, Year) FGBRUARY 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00000 ROPHAEL

5601 LOCE RAVEN BLUD BALTIMORE MO 21239 32. Registrar's Signature

Spale

State Registrar

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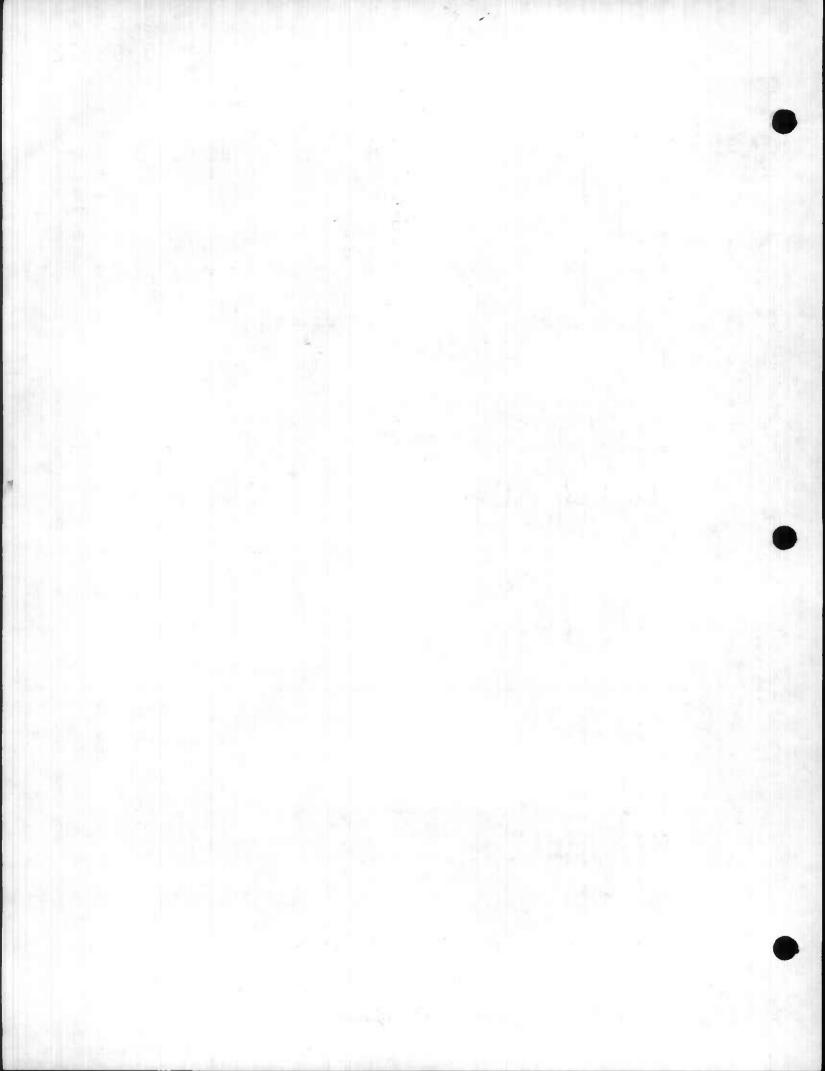
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/Medica Examine		la Facility Neme (If not institution, given 227 SOUTH BROAD)	re street and number)		4b. City, Town, or Loc	ation of Death	4c. County of	Death			
Funeral			Sex 7. Age (In yrs. le	ast birthday) If Under 1 Ye	BALTIMOR Bar If Under 24 Hrs.	8. Date of Birth (Month, Day,	N	9. Birthplace (State or Foreign Country)			
Director		234-94-9143 Usual Residence of Decedent		Yrs. Months De	ays Hours Min.	(Month, Day, Sep.T. 3	Year) 1937	W. VIRGINIA			
ms 23a or 28a-f show		10a. State 10b. County		Town or Location				10d. Inside City Limits 1. ✓ Yes 2 □ No			
r 28a-f show	5	MD, MI	4	BALTO 101. Zip Coo		10	g. Citizen of W	·			
23a or	a D	227 S. BRO	ADWAY	2	1231			USA			
	by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U,\$ Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		of Hispanic Origin? (Spec Cuban, Mexican, Puerto F No Specify:	city Yes or No- lican, etc.)		- American Indian, t, White, etc.			
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State of Maryland / Department of Health and Mental Hygiene 0 04972

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T is a	19a. Informant's Name/Rejetionship (Carolyn Wilson (and Number or Ru y, Crofto			State, Zip	Code)		
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certificate rector, pag	25. Was case referred to medical					26. Place of Dea	th (Check only or	1.				
	axaminer? 1 Yes 2 No	Hospital:	t 2 ER/Outp	atient 3 D	OA OB	hor	ome 5 20Reside		ar (Specify)		
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Neithin Me	29b. Signature and title of certifier			29	c. Licens	se number	2	9d. Dete signe	d (Month, D	Pay, Year)		
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6	30. Name and address of person who	completed cause of de			Kuy	, Aun	igrole.	les	211	90 (



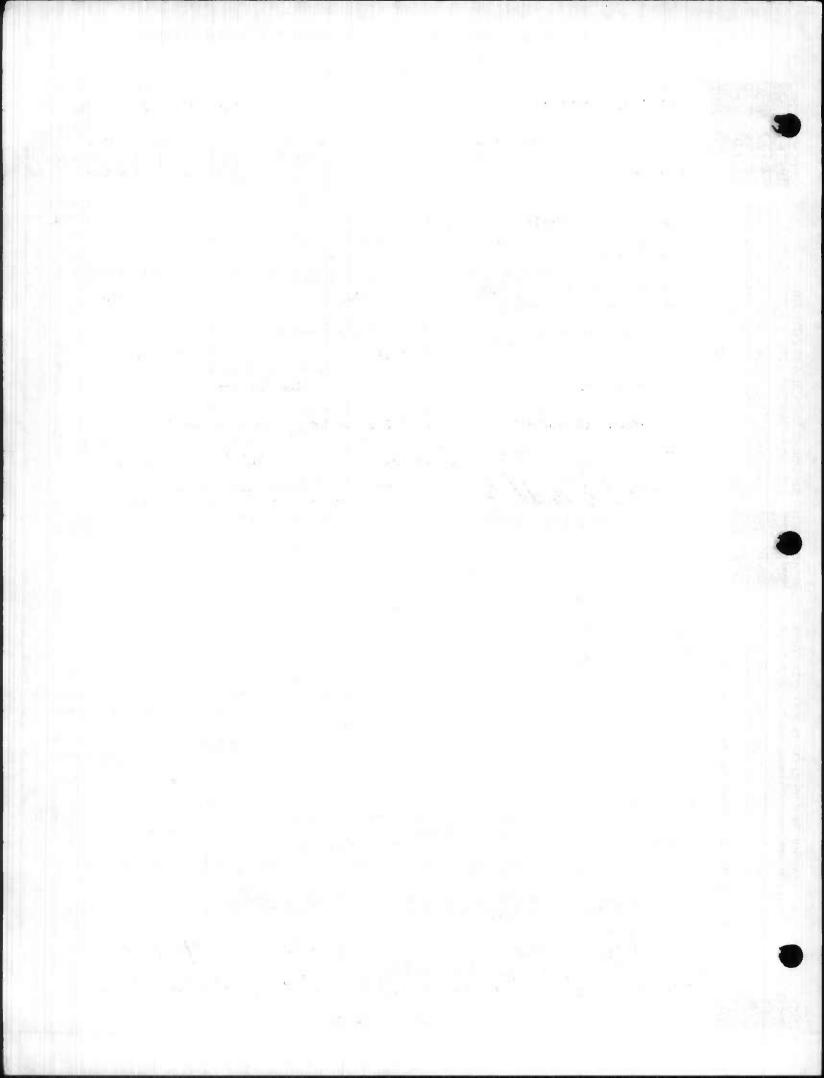
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples must be notified at 2016.	5		,					ation							1		City Limits
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within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai		2 Medical Exa	minar: On tha b	pasis of a	xamination and	d/or inva	stigation,	, in my c	opinion, daa	th occur	rad at tha tim	a, data	and place,	and dua to	tha caus	a(s)
within 24 hours To the Funeral completely filled	Me	29b. Signature and I	itigolycertifier			-		290	c. Licens	sa number			29d.	Data signe	d (Month, I	Day, Year)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#1 & 16a-b BERUK.B. G780 2-16-2000 JAB Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Vear **Physician** ELIJAH MICHAEL BROWN 07:34 21, 2000 Linvary /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street end number) 4c. County of Deeth Examiner Baltimore BALTIMORE HOSPITAL ST. HGNES If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1)K(M 2□ F A JANUARY ZI, 2000 **Director** 34 MARYLAND Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f short must be nothed at MD Yes 2 No Director BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? WILDWOOD 21229 1310 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: r than "natural", or items the Medical Examiner m Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien. 11. Maritai Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Saitimore, Maryland 21215-0020 Specify: BLACK À 3 Widowed 4 Divorced eted 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compl Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) INFANT 0 other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Peges 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or exercise. h and Mental h Be 8 BROWN INCENT BROWN HUGH SURINDER TIFFANY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) - SURINDER TIFFANY BROWN 1310 WILDWOOD PARKWAY BALTIMORE MD 21229 MOTHER 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Suriel 2 Cremetion 3 Removel from State Dete 200. Location - City or Town, State ay 2000 Baltim or, Md agnes Health Care 4 □ Donation 5 □ Other (Specify) 22. Name end Address of Feclity 21. Signeture of Funeral Service Licensee Hudre Lewis Gagnes Health Care 900 Caton Ave. Balto Hd er 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** 2 hours 34mm /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting In deeth) Lest buriel-tran Due to (or es e consequence of): end Rupture of Membranes Yreterm physician Physician/Medical the Due to (or es a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Twin Gestation by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed TWIN A January 10, 2000 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitai: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Deeth 1 2 Natural 28e. Dale of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation deeth. 2 Accident 1 ☐ Yes 2 ☐ No after deeth Diractor: 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ծ 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and manner ss stated. Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. edical 29e. Certifier (Check only one) To the To the I 29b. Signeture and little of couliffer 29c. License number 29d, Dete signed (Month, Dev. Year) 30. Name and eddress of person who completed ceuse of death (Item 23e) (Type, Print) Stagues fealth Care 900 Caton Are Bal

State Registrar

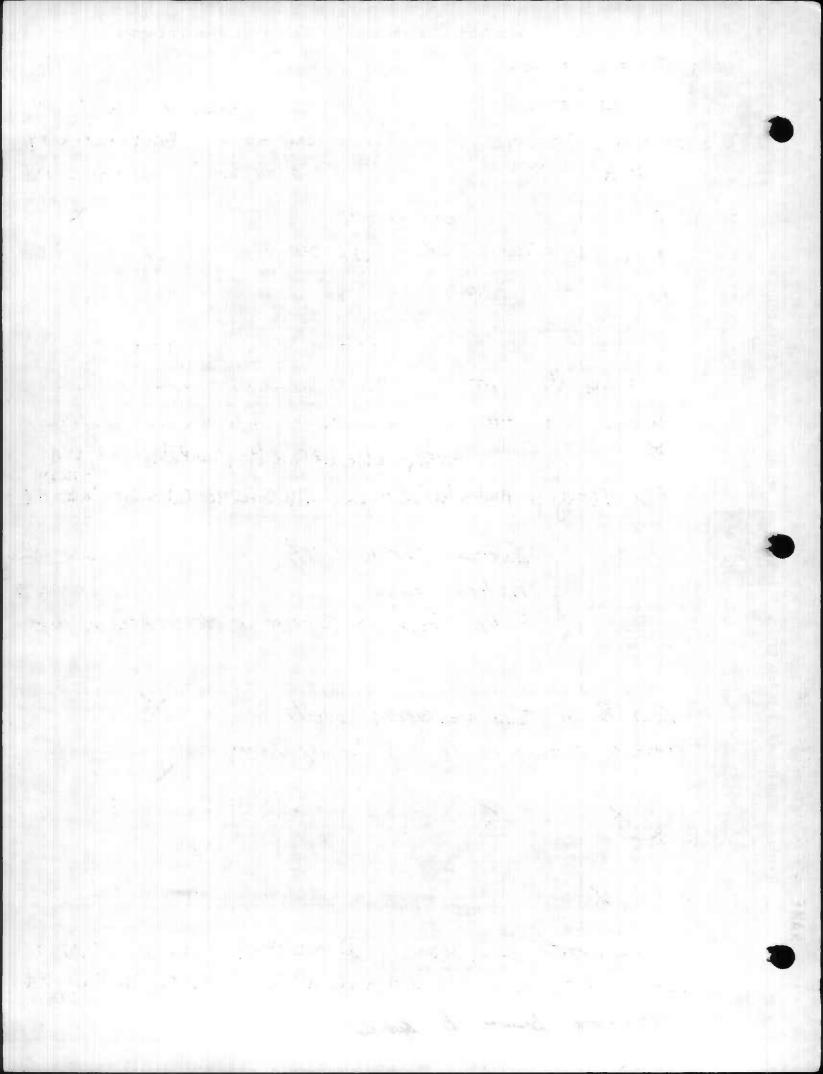
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31. Date filed (Month, Day, Year)

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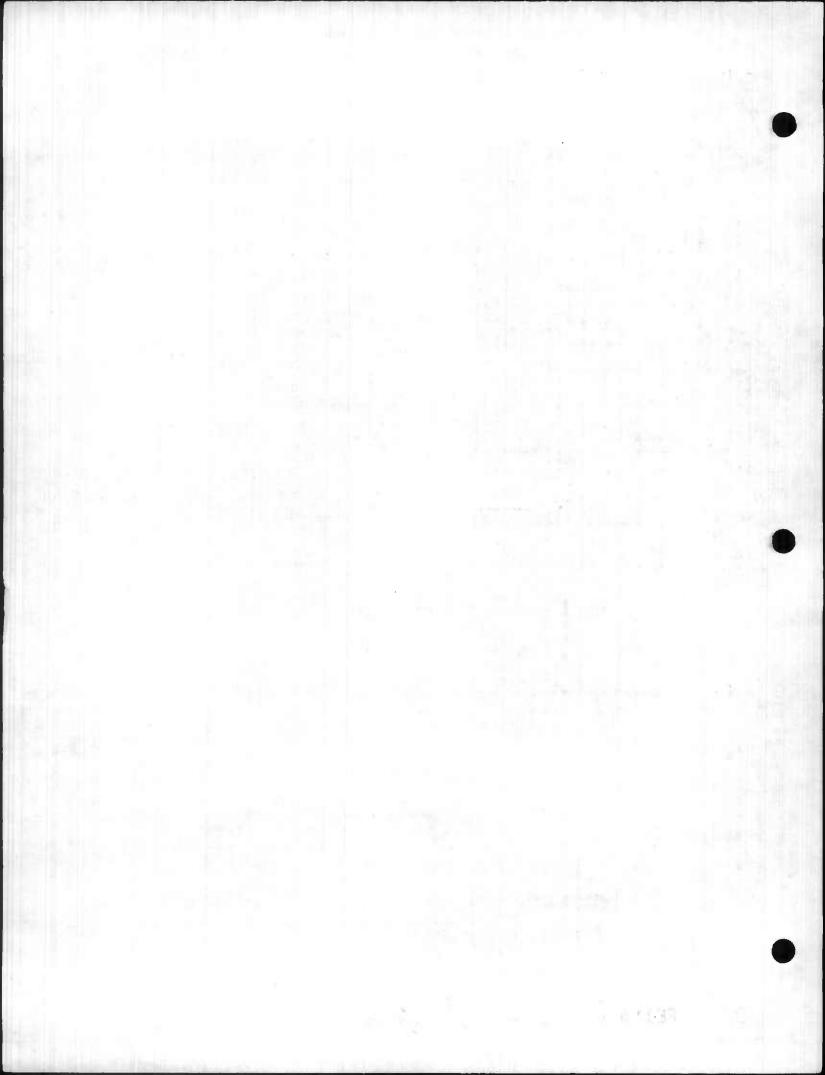
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32. Registrer's Signature



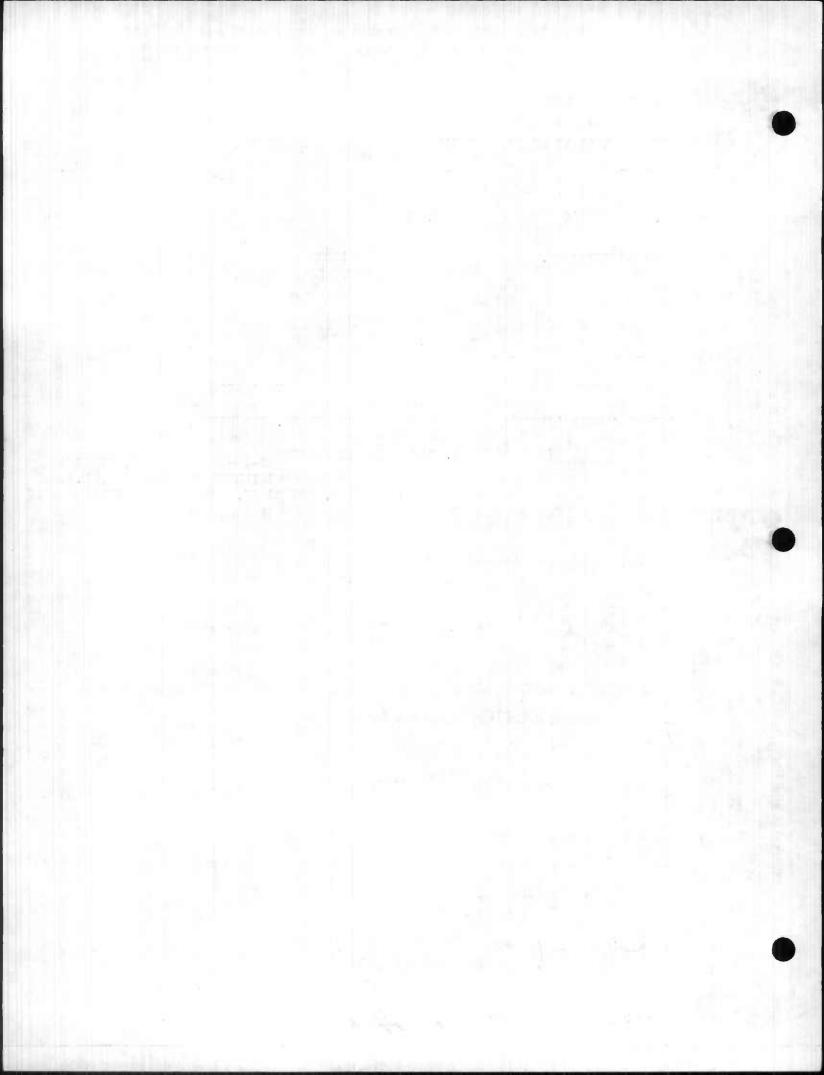
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ı	and the second s		5 Other				ODL					2000				
	22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 210															
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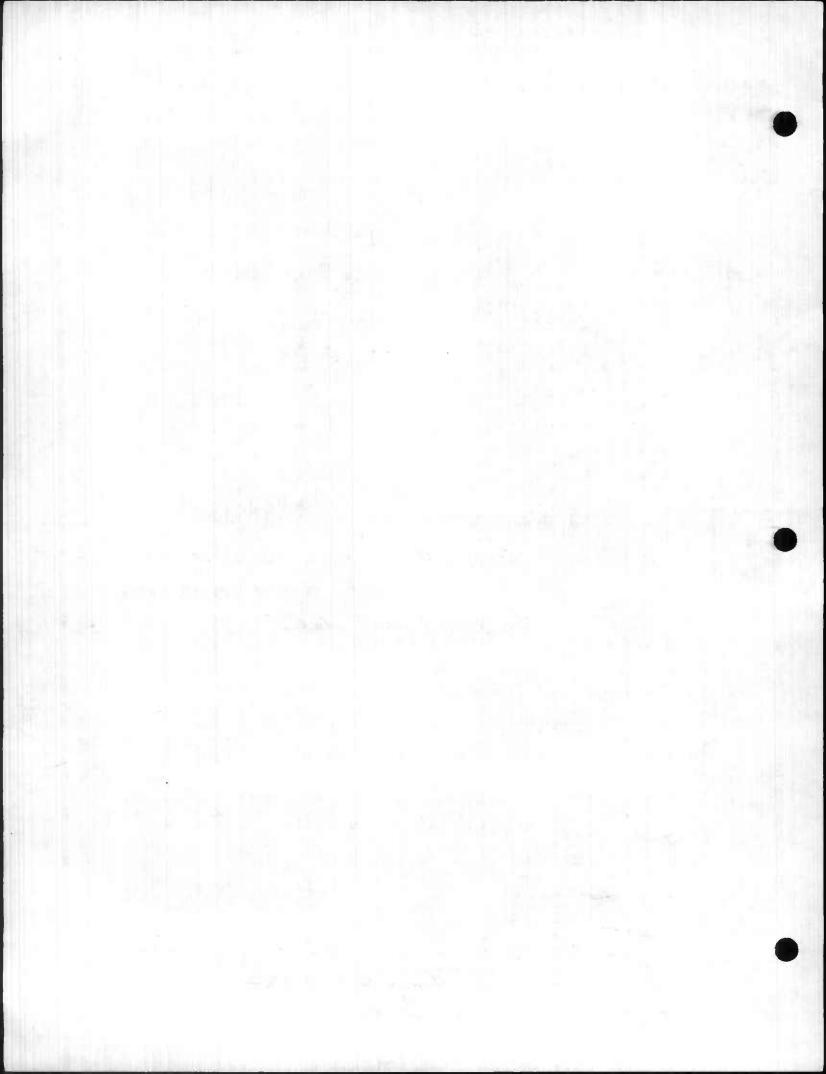
State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 00 Month Day Year **Physician** SHIRLEY ANN CLARK FEBRUARY 14,2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth / 4c. County of Deeth Examiner BALTIMORE
If Under 24 Hrs. 8.1
Hours Min. AT MERCY HOSPITAL STELLA MARIS 9. Birthplace (State or Foreign Country) \(\text{V} \Delta \) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 F 225-60-4990 VA. Director Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ♥ Yes 2 No Director MD. N/A BALTIMORE 288-0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Serve 23a 2909 DUNMURRY RD 21222 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stetus Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☑ No Specify Specify: BLACK à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Hyglene. Other then 'n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahould be fitted w Department of Health and Mental Hygien Importanti if them 27 is marked other th any Injury or other traumeter -12-HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 88 ALBERT CARTER MARY STOKES 19e. Informent'a Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERRY JACKSON (NIECE) 4922 FLETCHER RD. GLOUESTER, VIRGINIA 23061 20b. Place of Disposition (Name of cemetery, cremetery or other place of PAUL BAPTIST CHURCHERY 20a. Method ot Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel trom Stete ST. CHURCH 4 ☐ Donetion 5 ☐ Other (Specify) 2-16-2000 JAMAICA, VIRGINIA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Purit. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each tine. Approximata Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine physician and the burlat-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Due to (or as a consequ Box 68760. Physician/Medical Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yea 2 No 3 Probably aigned b Records. þ 24b. Were autopsy tindings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? 2 2 No 120 1 Yes 2 No Division of Vital AT MERC 25. Wes case referred to medicat examiner? Be 26. Place of Deeth (Check only one) STE // A MARIS Other: 4 Nursing Home 5 Residence 6 Other (Specify) #OSPIC Hospitel: 1 Yes 25 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, tectory, office building, atc. (Specify) 4 Homicide Medical 29e. Certifier →☐ Cartifying Physician: To the best of my knowledge, death occurred at the time, data end place, and dua to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signature and titla of purplus 29c. License numbe 29d. Dete signed (Month, Dey, Year) 14,2000 M TEBRUARY 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) BAltiMORE PRO 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State FEB 1 8 2000 Registrar



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State of Manyland / Department of Health and Mental Hygiene 0 0 1, 0 7 7

			State of Marylar	•	ate of Death		eg. No.	049	11				
	Physician /Modical	1. Decedent's Name (First, Middle, Last	"Martina	R. I	avis	2. Date of Deal Month	h Day	Year 3.	Fine of Death 8,15 P.M				
	/Medical Examiner	4e Facility Neme (If not institution, give 3 495 Hills me	street and number)			Location of Death	4c. County						
	Funeral Director	5. Social Security Number 6. Se 213-72-5214		(Sast birthday) If Und Month	der 1 Yeer If Under 24 Hr	s. 8. Dete of Birth	Year) 1961	9. Birthplace Country)	(State or Foreign				
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th with the	or heres 23s or 23s-f sho miner must be notified at Furneral Director	10e. Street and Number 3495 Hillsmera	e Road	0 0 0	21207	1	Og. Citizen of W	That Country?					
020 vrs after des	M, or hars 234 Examiner must by Funeral	11. Merital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates;		cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue 20(No Specify:	Specify Yes or No- rto Rican, etc.)		- American Ir c, White, etc.	dian,				
21215-0020	ygiene. Ne then "neture It, the Medical E Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	sual Occupation work done during most of we use retired)	orking	16b. Kind of Bu	Mark						
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and 2 show	eath and k m 27 is mer her traume	19e. Informant's Name/Relationship (1) Leandrew Dav	is -Husband	34951	ess (Street and Number or F	Road 1	Woodla	wn, Hd	21207				
timore t. Pages t	rtment of H rtant: If lea spury or oth	20a. Method of Disposition 1 Burial 2 Cremetion 3 F Donation 5 Other (Specify)	Removal from State	Place of Disposition (for cemetery, crematory of Caney (Jalley	2-19-00	IMOU;	City or Town,	State				
Ball	Depa Impo	21. Signature of Funeral Service Licens	March	Man 430	o wabash	Avenu.	e Bal	to red	2/2/5 proximate				
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58760, licate be executed	2 E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): LiRe Couse (Disease or injury that initiated events resulting in death) Last											
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P.O. E	d by the eteche	Pert II. Other significant conditions co	ntributing to death but not re-	sulting in the underlyin	g ceuse given in Part I.	23b. Did to		ise contribute to the cause of death					
I Records, P.O. The law requires that the	been shoul					24a. Wes a perform	n autopsy ned?	availab	outopsy lindings le prior to ation of cause h?				
tal Re	or, page 2	25. Wes case referred to medical				1 🗆 Y	/ -	1 ☐ Ye	s 2 No				
Division of Vital or Attending Physician: T	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	axaminer? 1 Yes 2 No 27. Menner of Death Natural 5 Pending	Hospitel: 1 Inpatient 2 28a. Dete of Injury (Month, Day Year)	28b. Time of tnjury	Other	Home 55 Beside	ence 6 Othe						
Division	within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Hornicide determined	28e. Placa ol Injury - At h building, etc. (Speci	nome, farm, street, fact		28f. Location (Si City or Town	treet and Number, State)	er or Rural Ro	ute Number,				
Hospit	in 24 hour he Funera pletely fill edical	29e. Certifier (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinating and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and plac on, in my opinion, deeth occ	ce, and due to the courred at the time, d	ause(s) and ma ete end place, a	nner as stated and dua to the	cause(s)				
Tott	To the comp	29b. Signature and title of certifier	-21		29c. License number 29.429.75	2	9d. Date signed	(Month, Day, 2/200	Year)				
	100	30. Nama and address of person who co		m 23a) (Type, Print)	10 2/28	7	1.						
	State Registrar	31. Date liled (Month, Day, Year) FFR 1 8 2000	Service Sign		7								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day February 17, 2000 Edgar A. Eder 7:30 AM 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 9102 Swiven Place, Apt. 3D Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 21, 1925 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 110 M 2□ F Months 214-20-8369 74 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9102 Swiven Place, Apt. 3D 21237 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Union 12th Grade Electrician 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Earl Eder Lorretta Mockadee I. 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9102 Swiven Place, Apt. 3D, Baltimore, MD Mrs. Carolyn E. Eder (wife) 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Parkwood Cem. Mausoleum 2/21/00 Baltimore, Maryland 4 □ Donetion 5 Ø Other (Specify) Entombment 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediete Ceuse (Final disease or condition resulting in deeth) Pneumonia week Due to (or es a consequence of): LUVS concer months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inflieted events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Tyes 2 No investigation

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: if Nem 27 is marked other than any injury or other traumatic event, on the Mental Bental.

Physician **...**

/Medical

Examiner

Director

Funeral

P

Completed

Be

Funeral

Director

Show

rithan "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death

21215-0020

altimore, Maryland

Examiner The law requires that the death certificate be executed P.O. Box 68760, Physician/Medical Records, Completed by Be edical Certification: To

To the Hospital or Attending Physician:
within 24 hours after death.
To the Funeral Director: After this certifical
completely filled in by the funeral director. E.

Division of Vital

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Mennerof Deeth

29a, Certifier

(Check only one)

1 Netural 2 Accident 3 Suicide 4 Homicide

6 Could not be determined

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number

281. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier autin Dagle us

1023809

29d. Dete signed (Month, Day, Year) 2/17/00

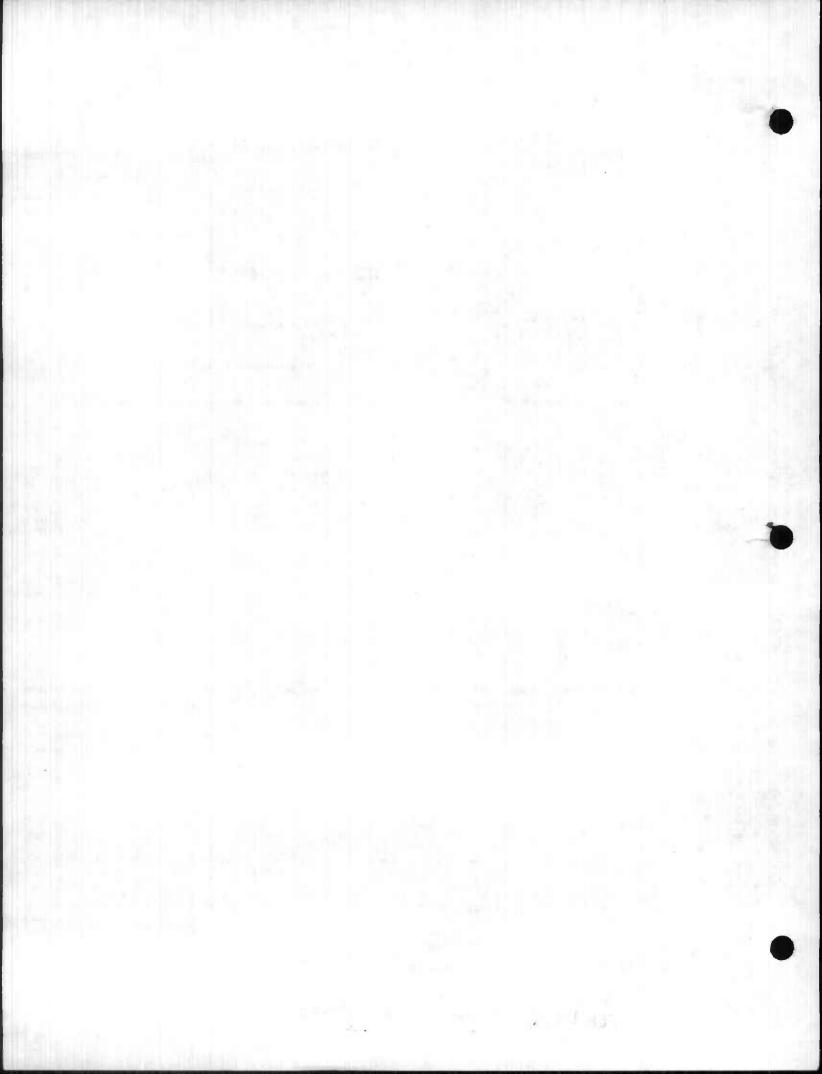
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ctr., 22 S. Greene St., Baltmore, MO 21201 Austio Doyle Mo, Greenebaum Cancer 31. Dete filed (Month, Dey, Year)

State Registrar

FEB 1 8 2000





Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Day Year EVA FRIESNER 15:31 FEBRUARY 12 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Yeer Months Days If Under 24 Hrs. 8. Dale of Birth (Month, Dey, Year) Nov. 20,1916 5. Social Security Number Birthplace (State or Foreign Country) Hours 1 M M M F 218-05-7457 83 Michigan Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 20 No Edgemere Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6807 North Point Road 21219 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Meritel Stetus Black, While, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Tin Sorter Steel Industry Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Mathew Sakowski Mary Kutz 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan M. Ryan (Daughter) 7843 Rockbourne Road Dundalk, Maryland 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 12 Burial 2 ☐ Cremetion 3 ☐ Removal from State 2/16/00 Parkwood Cemetery Baltimore, Maryland 4 ☐ Donallon 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland or samplications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, and one cause on each line. 23a. Part1. Enler the drags Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): STROKE Due to (or as a consequence of):

Physician /Medical Examiner

attending physician and for use as the burial-transit

page 2 s

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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Hygiene.

h and Mental h Pages 1 and 2 should be nent of Health and Mental

of Health Itam 27 I

Department of Important: If Is any Injury or o

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filed within 72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION

Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

FEBRUARY 13,2000

DIABETES				24a. Was an autopsy performed?	24b. Wera autopsy finding available prior to completion of cause of death?
25. Wes case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ② No	Hospital: 12 npatient 2	ER/Outpatient 3□ [OOA Other: 4 Nursing	Home 5 Residence 6 □Oth	ner (Specify)
27. Manner of Death 1 Natural 5 Pending investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred
3 Suicide 6 Could not be determined		nome, farm, street, factory)	28f. Location (Street end Numi City or Town, State)	ber or Rural Route Number,	
29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1	nysician: To the best of my kni niner: On the basis of examination and manner stelled.	owledge, death occurre ation and/or Investigation	d at the time, dete and plac on, in my opinion, death occ	e, and due to the cause(s) and murred at the time, date and place,	anner as stated. and due to the cause(s)
29b. Signature and title of certifier		2	9c. License number	29d. Dete signe	d (Month, Day, Year)

20306

State

Registrar

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director; to

31. Date filed (Month, Day, Year) FEB 1 8 2000

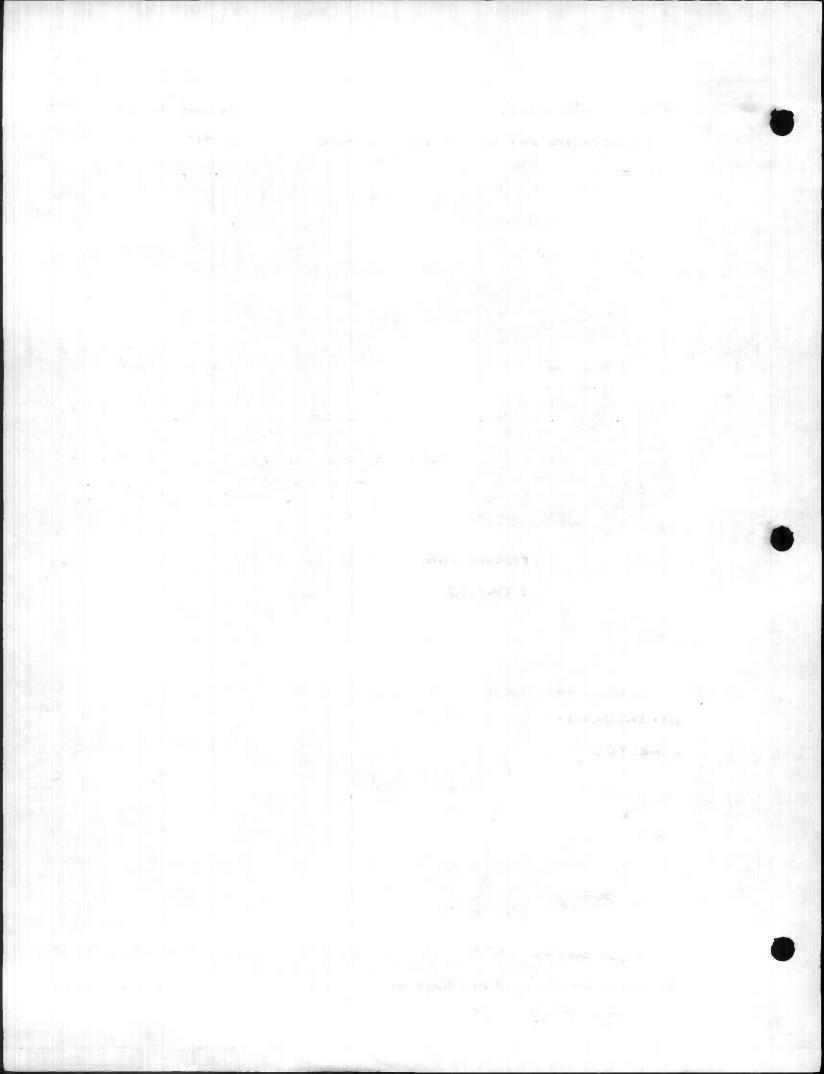
VANDANA RAMULU

Villaula, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224 32. Registrar's Signeture sports

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13, 2000 February Helen J. Fawcett 8:25 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 236-24-7816 1 M 2 F Yrs. Director Feb. 15, 1924 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits whow. re 23a or 28a-f shor must be notified at Baltimore 1 ☐ Yes 2 ☐ No Catonsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or itserts 23s or 717 Maiden Choice Lane ST611 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, parmit. Pages 1 and 2 should be filed within 72 hours after. Important if them 27 is marked other than "natural"—any injury or other traumatic average. Bleck, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married White 1 Yes 2 XNo Specify: Specify: à Yes, Give Yeer or Detes: 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) å Deney W. Jarrett Katherine Penix 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) James F. Fawcett (Husband) 717 Maiden Choice Lane ST611, Catonsville, MD 21228 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removet from State Crestlawn Memorial Park 2/17/00 Marriottsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Fuperal Service Licenses 1630 Edmondson Avenue, Catonsville, MD 21228 urne 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical hours Precmonia Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were sutopsy lindings available prior to completion of cause of death? 24e. Wes en autopsy parformed? Completed page 2 s 1 Yes 2Æ No 1 ☐ Yes 2 ☐ No Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical etaly filled in by the funeral director, 25. Was case referred to medical axeminer? 8 28. Place of Deeth (Check only one) 1 Yes 2 No
27. Menner of Death Other: 42 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28l. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 4 Homicide Medical 29e. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. Vithin 2 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) UM D 30. Neme and address of parson who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year)
FEB 1 8 2000

425,5

Andrew

32. Registrar's Signeture Benev B. Sparks

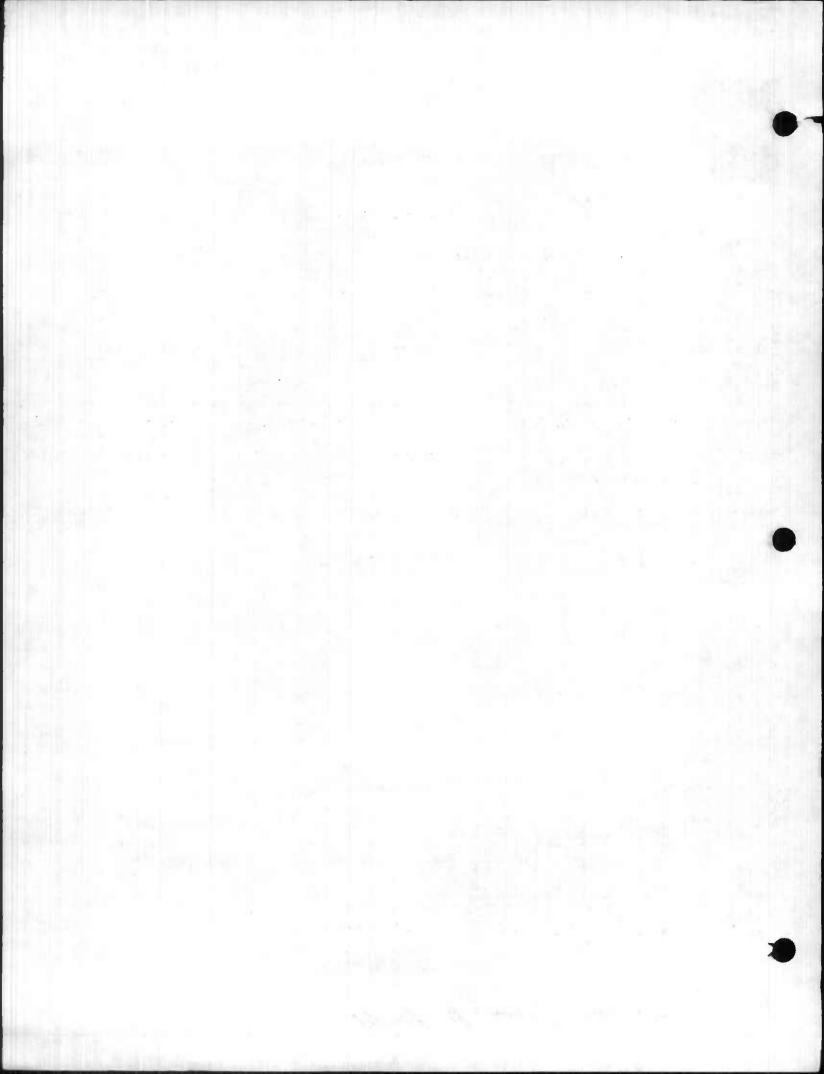
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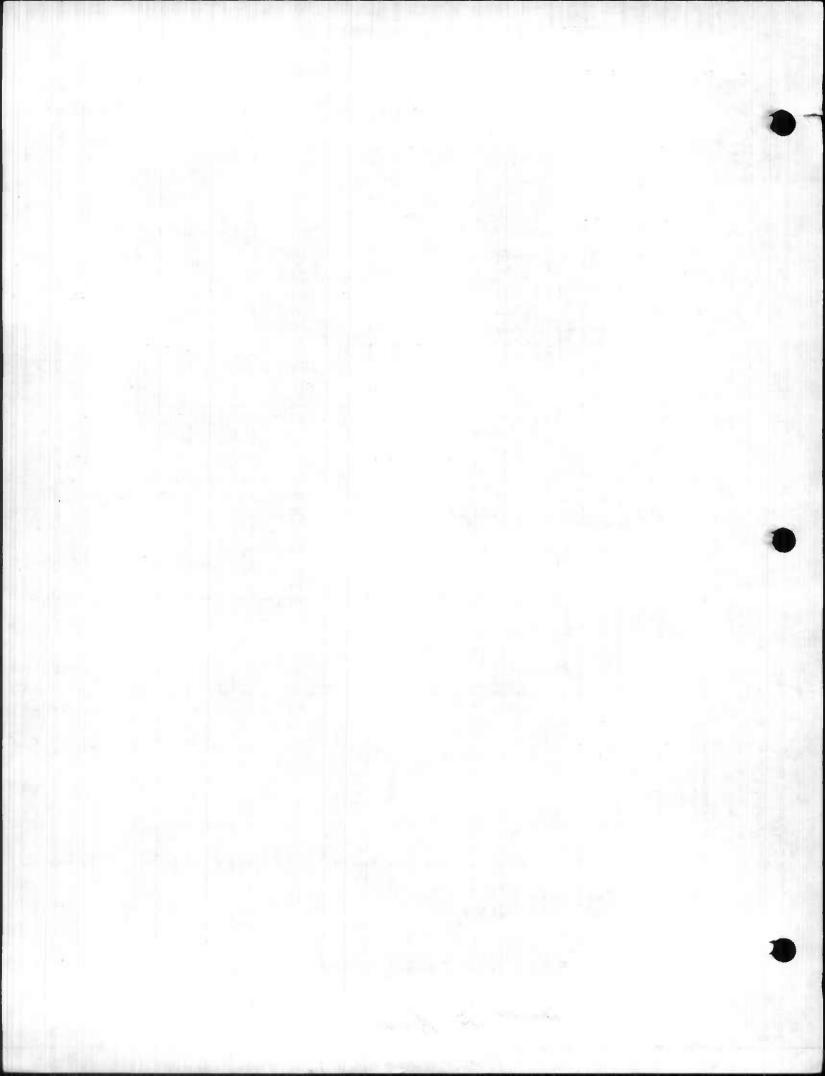
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Catus ville Margland.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item # 10e.per FH.G780.2/18/2000.gap Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Vear **Physician** ladys ishman 15 10:00PM ebruary 2000 /Medical 4b. City, Town, or Location of Death 4d County of Death 4a Fecility Nama (If not institution, give street and number) Examiner BALTIMORE Hopkins 7. Age (In yrs. last birthday) N/A The Johns If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) APR. 10, 1941 Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Deys Hours 220-36-2688 58 N.Y. Director Usual Rasidence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 7 28a-f show notified at 10d. Inside City Limits MD BALTIMORE 1 Nas 2 No N/A Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code na 23a or i 105-B CROSS KEYS DRIVE 21210 ROAD U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11 Marital Status Black, Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: WHITE Specify þ 3 Widowed 4 ☐ Divorced Year or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 PROPRIETOR DRY CLEANER Pages 1 and 2 should be flied w ment of Health and Mental Hygist tant: if Item 27 is marked other to jury or other traumatic event, the 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be **ABRAHAM** FISHMAN FRIEDA KURSHNER 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERI UFFER / DAUGHTER 724 MILFORD MILL ROAD - BALTIMORE, MD 21208 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Othar (Specify) 2/17/00 DRUID RIDGE CEMETERY PIKESVILLE, MD 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximata Interval Between Onsal and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Physician /Medical Immediata Causa (Final renal failure diseasa or condition resulting in death) Examiner Due to (or as a consequence of): 28 days Physician/Medical Examiner Cardiomyopath iclan and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician the bunal Box 68760. Dua to (or as a consequence of): 88 igned by the strendin be detached for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 Dthknown 1 Yes 2 No ungemia Records, þ 24b. Wera autopsy lindings available prior to Completed gastrointestinal bleeding 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes casa referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yas 2 No 1 Unpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28d. Describe how injury occurred 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 (Matural 5 Pending investigation 1 Yas 2 No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be detarmined 3 ☐ Suicida Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai completely (Check only one) To the To the F 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) RES-000 02-15-2000 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) Ahuja Street, Baltimore, 600 Nita North 31. Data filed (Month, Day, Year) FEB 1 8 2000 32. Registrar's Signatura Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 04982 Certificate of Death Amended Item # 5,2/23/2000, Per FH, G780, gap 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Garrison 12:00 AM Richard R 2000 Febr 4b. City, Town, or Location of Death 16 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5. Social Security Number 6. Sex 7. Age 127-18-1378 120 F HILDER Baltimore 7. Age (In yrs. last birthday) If Under 1 Year more If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months Hours Director 03-07-24 Usual Residence of Decedent the Maryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow NA 1 Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in and Mental Hyglone.
Int: If team 27 is marked other than Instituti, or flores 23a or it usy or other traumatic avent, the lead of the mental or or other traumatic avent, the lead of the mental or or other traumatic avent, the lead of the mental or or other traumatic avent, the lead of the mental or or other traumatic avent, the lead of the mental or or other traumatic avent, the lead of the mental or or other traumatic avent, the lead of the mental or or other traumatic avent, the lead of the mental or or other traumatic avent. 3402 WOODBROOK ANE. U.S.A. 21217 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1-QYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: BIACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STEEL Negotiator NONE Baitimore, Maryland 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) KICHARD GARRISON HILDA HALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BERNICE GARRISON (Wife) 3402 WOODBROOK AUE. GALTIMORE MD. 21217 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If Its any Injury or o 1 Burial 2 □ Cremation 3 □ Removel from State CARRISON FOREST VETERON CENETRY 2-23-200 OWENGS MILLS MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. HOUTON & SONS MOI LAUDENS STREET BALTIMORD, MARYLOUND 2217 ales rines 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Abrillation atrial Examiner Due to (or as a consequence of): Physician/Medical Examiner ng physician and as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 68760 that initiated events resulting in death) Last Due to (or as a consequence of) Box (987 P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by d be detact 1 ☐ Yea 2 ☐ No 3 ☐ Probably Munknown Nupertension Records. g 24b. Were autopsy tindings aveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy chronic obstructive pulmenay discore premonio 1 | Yes 2 □ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical 8 26. Place of Death (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral o 28c. Injury at Work? 27. Manner of Deatl 28d. Describe how injury occurred Certification: I or Attending P. after deeth. After Netural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) resident

Registrar

State

DHMH 16 Rev 6/95

Baltimore,

Physician

ted cause of death (Item 23a) (Type, Print)

MM

Green

31. Date filed (Month, Day, Year)

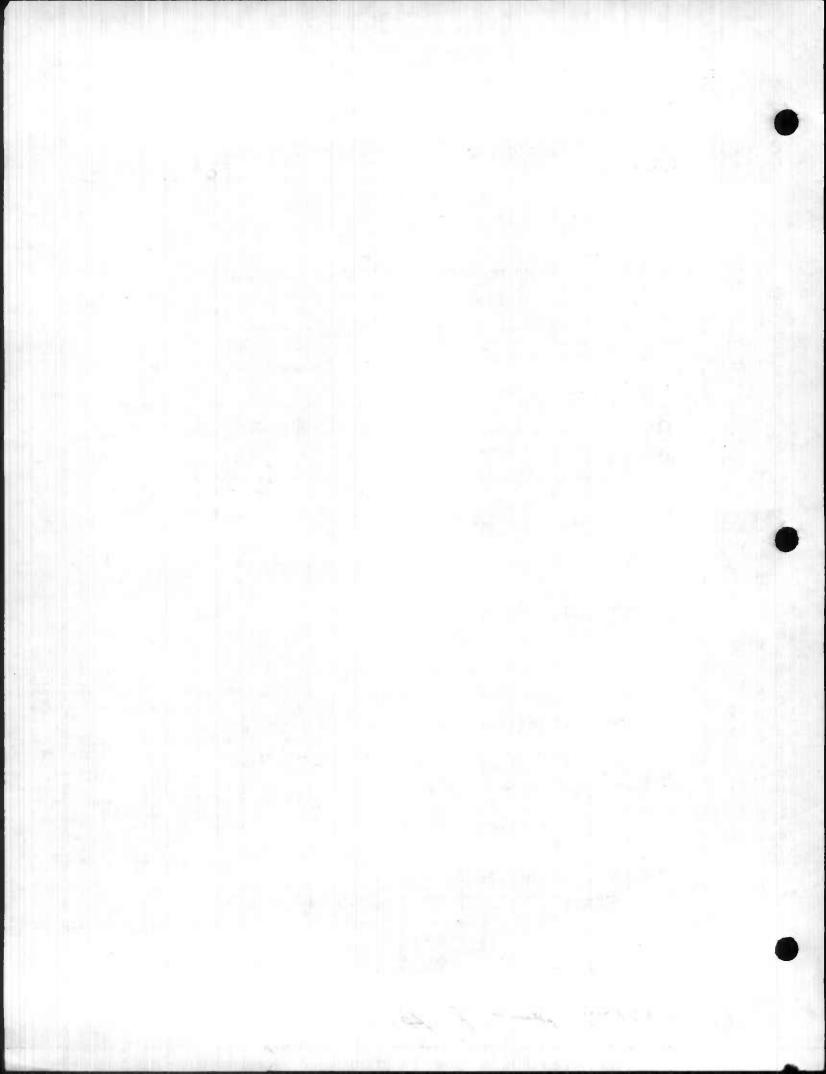
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32. Registrar's Signature

PIQA3

16,2000



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician	
/Medical	
Examiner	

Funeral Director

with the Maryland ahow 28e-f ms 23s or death

the Medical Examiner filed within 72 hours after Hygiene. Wer then "neturel", or its Pages 1 and 2 should be Illi ment of Health and Mental H lant; if Nem 27 is marked oth lary or other traumatic even Department of Important if any injury or once.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

of Vital

Division

Physician /Medical Examiner

sician and burial-transit The law requires that the death certificate be executed physician s the burial signed b page 2 or Attending Physician: this funaral Affect To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun edical

1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Charlotte P. Haskin February 17 2000 12:35 am 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare - Spa Creek Annapolis Anne Arundel 8. Dete of Birth (Month, Day, Year) Sept. 3, 1934 Minnesota If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys Months Hours 1 M 2 X F 65 Yrs. 471-36-0573 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limits MD Anne Arundel Gambrills 1 Yes XXNo Directo 10a Street and Number 10f Zin Code 10g. Citizen of What Country? 1505 Defense Highway 21054 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Biack, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 T Never Married 200 Married 1 Yes 2KNo Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Adolph Leonard Green Phyllis V. Erickson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maynard D. Haskin (Husband) 1505 Defense Highway, Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 02/23/ ₩Burial 2 Cremation 3 Removel from State Hillside Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Minneapolis, MN 21. Signature of Fungal Service Licensee 22. Neme end Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, tonly one cause on each line. Approximate Intervel Between Onset end Deeth Periphen Vasalo Lisease Immediate Cause (Finat disease or condition resulting in death) 20 Examine Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably Unknown þ 24b. Were autopsy findings available prior to completion of cause ot death? Completed 24e. Wes en autopsy 1 ☐ Yas 2 ☐ 440 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

29b. Signature and title of dertifier

State Registrar 31. Date filed (Month, Day, Year, 32. Registrar's Signature FEB 18

2000

were, mo) 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print)

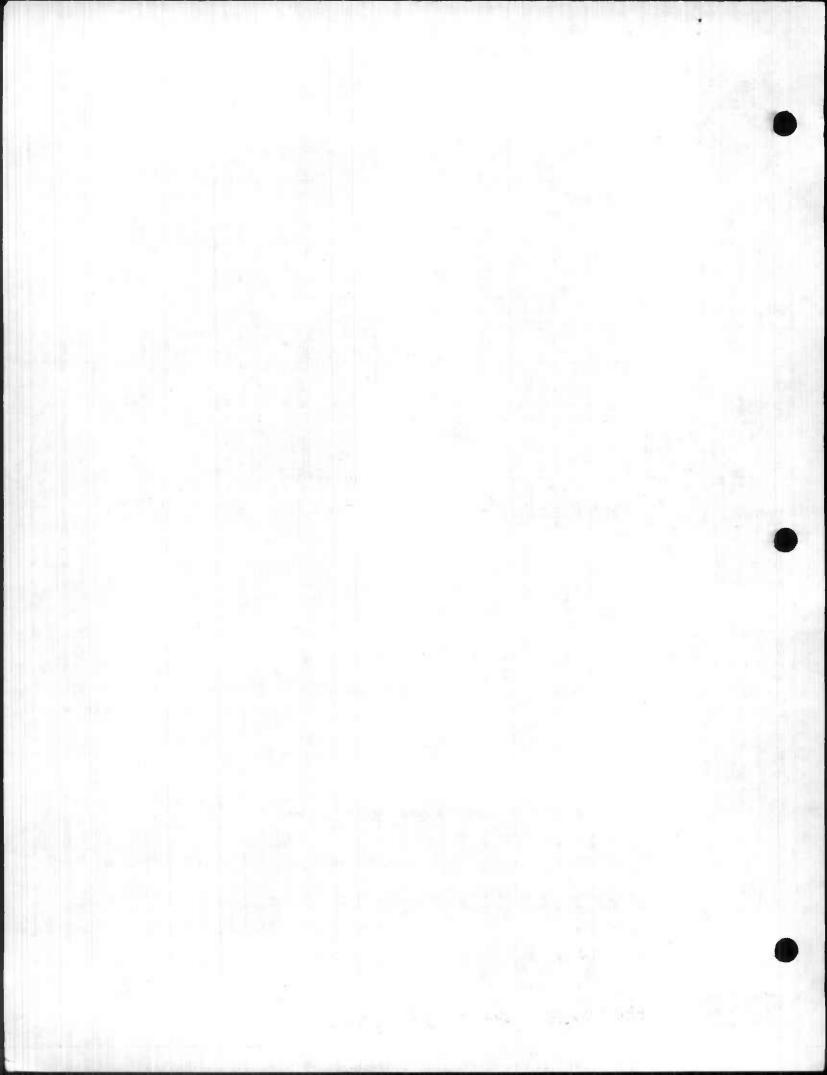
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

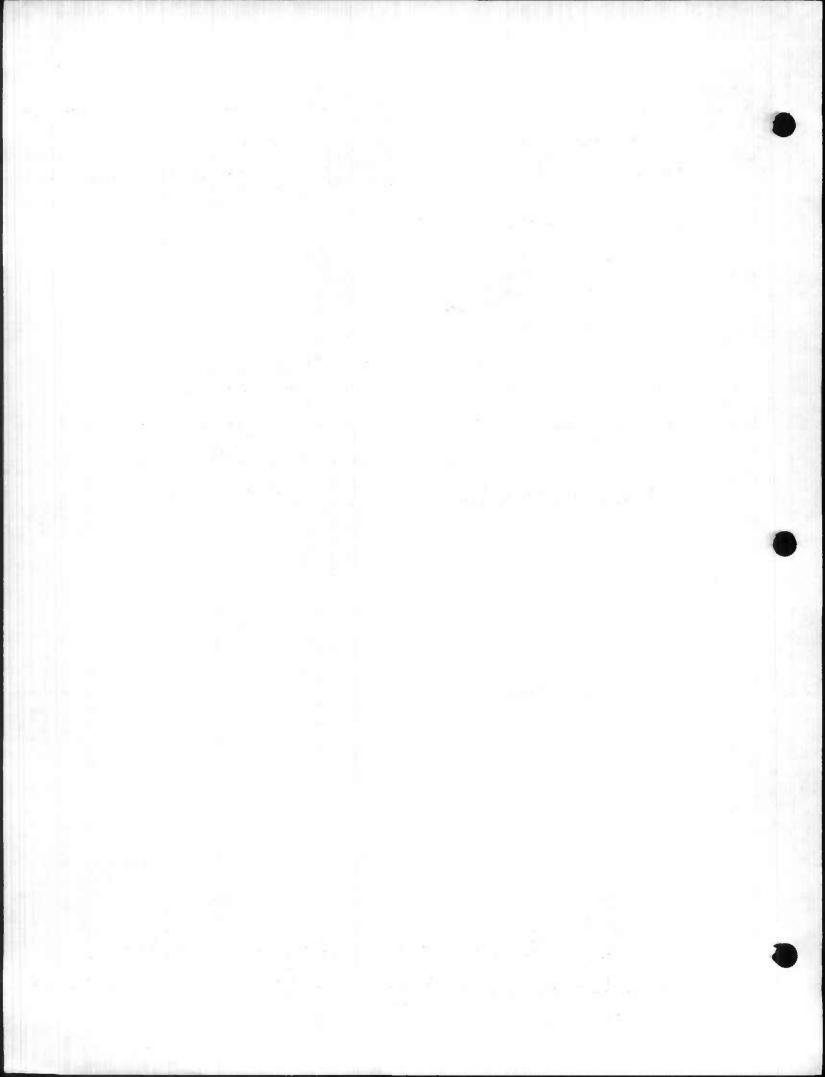
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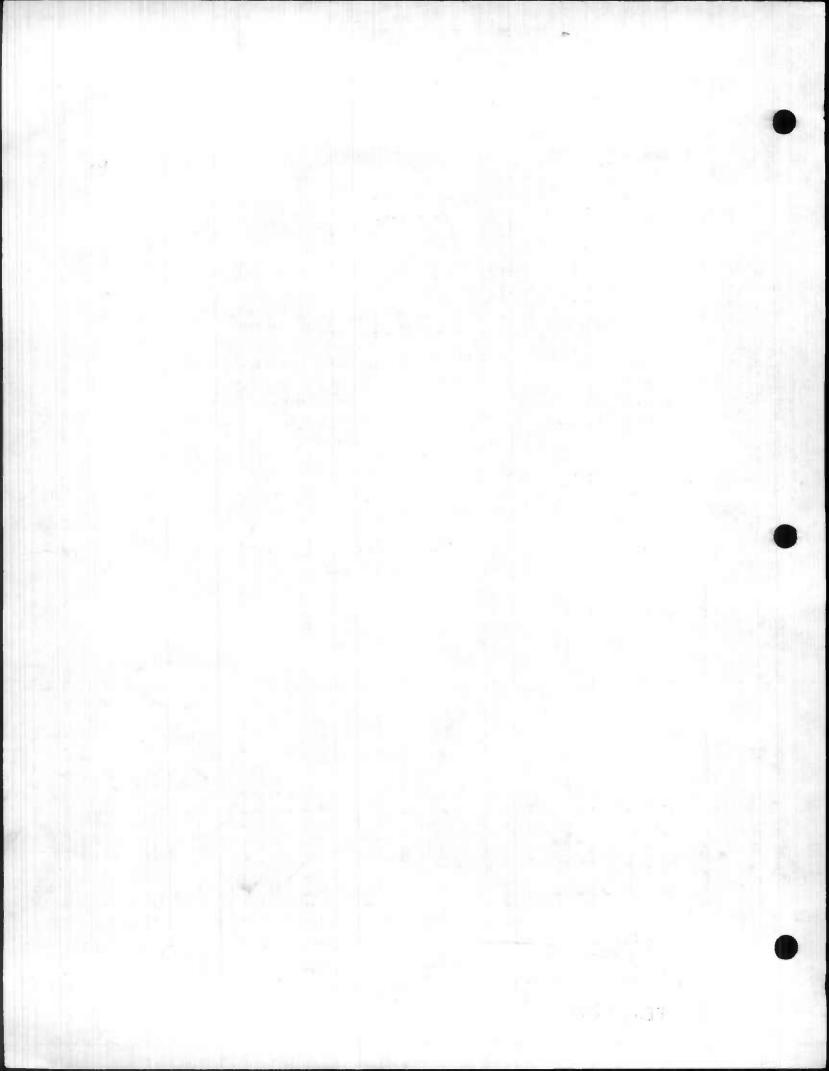
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	Physic /Medi		Paul Heffner								Febr	uary	16	2000	10:	30 pm
5	Exami		4a. Facility Name (If not institution, giv)			1	4b. City, To	wn, or Lo	cation of De	eth	4c. County	of Death		
			727 Charleston				H I to door				ville		Anne			
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	pud *		Usuel Residence of Decedent 10a, State 10b, County		10c. City.	Town or Lo	cation						·	10	d Inside	City Limits
	Manyl f sho	ō	MD Anne Arundel Davidsonville													es 2X No
	the 1	Director	10e. Street end Number	under	Dav.	Lusonv	10f. Zip (Code				10a.	Citizen of V	What Count	rv?	
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	fre 2:	era	11. Marital Status	12. Was Decedent	Ever In U.S	i. 13, V				aln? (Sp	ecity Yes or			a - America	n Indian	
020	within 72 hours efter deeth with the Maryland ene. than "natural", or items 23a or 28a-f show he Madical Examiner must be notified at	by Funeral	1 Never Merried 2 Merried 3 Widowed 4 Divorced	7 No 1952-		f Yes, speci 1 □ Yes 2		Specify:	, Puèrto	ecify Yes or Rican, etc.)		Specify	ck, White, e	ite		
Maryland 21215-0020	72 hours "natural",		15. Decedent's Ed	fucation	2702	16a. Deced	dent's Usuel	Occup	ation			165	. Kind of Bu	usiness/Ind	ustry	
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ore			20a. Method of Disposition 12 Suriel 2 Cremetion 3 C	Removel from State		oce of Dispo metery, cren	sition (Nam netory or of	e of her pied	ce)	1	02/19	200	. Location -	City or To	m, State	
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Baltimore,	permit. Peges Department of Important: If it eny injury or pace.		21. Signeture of Funeral Service Licar	S Pa	10			sty	Fune:	ral	Home,					
	-		23a. Pert1. Enter the disease, or com shock, or heart feilure. List only	plications that cause	d the death	Do not ent	12 Ri	dge of dvin	ly Av	enue	Ann	apol	is, M	D 214	O1 Approxi	mete
8760,	cate be executed physician and the burial-transit	i Examiner	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury	b	Sair VIII	es e conseq										
20 x 68 /	death certificate e attending physied for use as the l	Physician/Medical	that Initiated events resulting In deeth) Last Due to (or as a consequence of):													
	death e afte	sicia	Pert II. Other significant conditions o	ontributing to death l	but not result	ting in the u	nderlying ca	use giv	en in Pert I.		23b. D	id toba	CCO USO COI	ntribute to	the cau	se of death?
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	ig Ph		27. Manper of Death 1 X Neturel 5 ☐ Pending	28a. Dete of Injui	ury 2	28b. Time of Injury	28	c. Injur Wor	y at k?		28d. Descri	be how l	njury occur	red		
<u> </u>	Attending or deeth.	atic	2 Accident Investigation	1	, , , , ,	,,	М		Yes 2 1	No						
DIVISION	al or Attending Physics after deeth. It Director: After this ed in by the funeral d	Certification:	3 Suicide 6 Could not be determined	286. Piece of in	jury - At hon tc. <i>(Specify)</i>	ne, ferm, str	eet, fectory,	offica			28f. Locatio City or	n (Stree Town, S		per or Rure	Route A	lumber,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by	edical	29e. Certifier (Check only one) 1 Certifying Ph	ysician: To the best niner: On the basis of end menner s	of examinetic	ledge, deeth on end/or Inv	occurred e	t the tin	ne, dete en pinion, dee	d place, th occurr	end due to t red et the tin	he caus ne, date	e(s) and ma and pleca,	anner as at and due to	eted. the caus	se(s)
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	17)		30. Neme end address of person who	700	Bes	taat	e RC	1, =	#30	D	An	nat	ohs	M	DZ	1401
	Sta Registr	200	31. Dete filed (Month, Dey, Year)		rer's Signetu	lie C	1		/		('				



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State of Maryland / Department of Health and Mental Hygiene 04985 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth February 16, 2000 **Physician** Francis J. Heilman, Sr. 12:36 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Johns Hopkins Hospital Baltimore Hours Min. Nature 1920 6. Sex 1 (X) M 2 ☐ F Birthplace (State or Foreign Country) ff Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Maryland 79 Yrs 217-03-8051 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner nout be notified at XXYas 2 No Directo N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code flarms 23a or 3748 Elmora Avenue 21213 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yaar or Datas: WWII 14. Race - Amarican Indian Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 No Specify: Specify: White ğ 3 M Widowed 4 □ Divorced Completed i fied within 72 h i Hygiene. other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Food Service permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if them 27 is marriad other th. any injury or other trauments Baker 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Be Heilman Edward Elizabeth Sudsburg 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Barbara E. Heilman / Daughter 3748 Elmora Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 2/19/2000 4 ☐ Donetion 5 ☐ Othar (Specify) Moreland Mem. Park Baltimore, Maryland 21. Signeture of Funerel Service Licensee Michael E. Canapp 22. Neme end Address of Fecility 5305 Harford Road LEONARD J. RUCK, INC. 21214 Baltimore, MD 23a. Part1. Entar the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Pulmenor /Medical Immediete Cause (Finel hous disease or condition resulting in deeth) Examiner that the death certificate be executed Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in deeth) Last pue Due to (or es a consequence of) Box 68760. attending physician Physician/Medical 100 Dua to (or as a consequence of) USB BS Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa coptributa to the causa of death? Records, P.O. signed by t d be detach 1 Yea 2 No 3 Probably 4 Unknown by Completed 24a. Wes an autopsy performed? 24b. Wera autopsy findings available prior to peen completion of cause of death? 1 Ves 2□No 1 Yes 2 No certificata Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificately filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 PER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Neturet 5 Pending 1 Yes 2 No invastigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner steted. within 2 To the 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifier MADY 30 Name end address of person who completed cause of death (Item 23a) (Type, Print) MO 31. Date filed (Month, Day, Year) 32. Registrar's Signal FEB 1 8 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death HAMILTON 03:24 JAMES FEB 15, 2000 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center N/A Baltimore City H Under 1 Year | H Under 24 Hrs. | 8. Deta of Birth (Month, Day, Year) | July 28,1925 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1XM 2 F 199-14-5111 74 Yrs. Pennsylvania Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yas 2 No Maryland N/A Baltimore City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5007 East Oliver Street 21205 United States 13. Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, atc. 1 Never Merried 2 Married 1 € Yes 2 No If Yas, Giva Year or Detas: WWII 1 Yes 21 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) College (1-4or 5+) 7 Years Baltimore City Empl. Maintenance Worker 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Robert Hamilton Louise M. Kirk 19e. Informent's Name/Ralationship (Type, Print) Wife 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Margaret Odessa Hamilton 5007 East Oliver Street Baltimore, Maryland 21205 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a, Method of Disposition Data 20c. Location - City or Town, Stets 1 Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2/18/00 Baltimore, Maryland 21. Signature of unaral Sarvice Licensee 22. Name and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter 17 disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or have failure. Est only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Finel diseesa or condition resulting in daath) Pneumonia Dua to (or as a consequence of) Emphysema Sequantially list conditions, if any, leeding to immediata causa. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or as e consequence of) Dua to (or es a consequence of) 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause 24a. Wes an autopsy

Physician /Medical Examiner

and

physician

this certificate

The law requires that the death certificate be executed

Box 68760.

P.O. |

Division of Vital Records,

Department of h Important: if he any injury or of

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

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Funeral

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Maryland 21215-0020

Baltimore,

Examiner Physician/Medical þ Be Completed

signed by the ate has been signated by page 2 should b lal or Attending Physician: The state death.

I Director: After this certificate of in by the tuneral director, pa Medical Certification: To

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 □ Yas 2 □ No 1 Yas 25. Was casa referred to medical 26. Place of Death (Check only one) examinar? Hospitel: 1 Inpatient 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Pending Invastigation 1 Yas 2 No 2 Accidant 3 Suicide 6 Could not be detarmined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Piece of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian 29b. Signeture and title of certifiar 29c. License number Hospital No. P20308 29d. Data signed (Month, Day, Year) Wen-Hiring Lee, M.D.

To the Hospital or Attervitin 24 hours after de To the Funeral Director completely filled in by the

Registrar

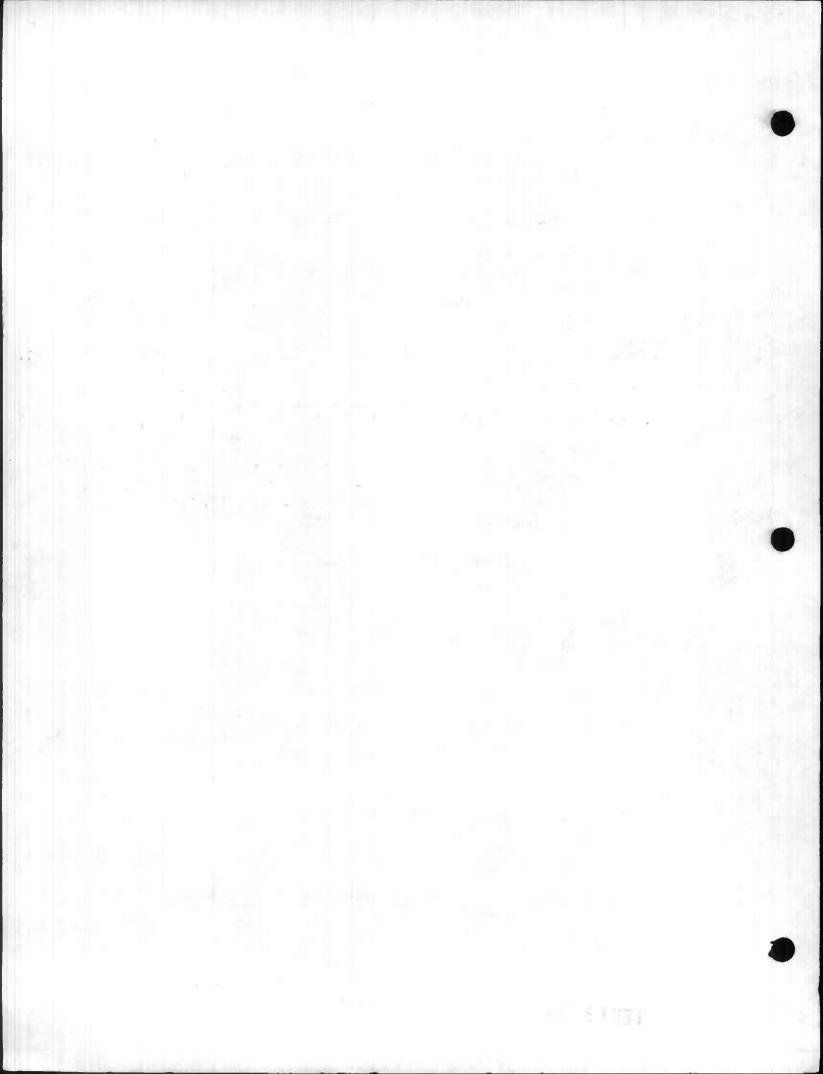
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

Johns Hopkins Bayview. 4940 Eastern Ave., Baltimore, MD 2/224

FEB. 15, 2000

Wen-Hsiang 31. Dete filed (Month, Day, Year, FEB 1 8 2000

32/Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death A. Johnson James Feb 2000 1009 (AH) 6 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Baltruse (edical Centra 1erci If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1 M 2 F Months Yrs 214-38-3507 MD 58 Usuai Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD NA Yas 2 No 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number USA 21205 1400 E. Madison Street 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedant of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Bueiness/Industry (Give kind of work done during most of working life. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) Amoco Steel Company Steel worker 12th Grade 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Carter Howard Johnson, Sr. Dorothy Robert 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 19a. Informant's Name/Relationship (Type, Print) 9822 Linden Hill Road Owings Mills, MD. Carolyn R. Brice 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition MBurial 2 Cremation 3 Removal from Stata Zion Cemetery 02-19-2000 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 21202 1101 E. North Avenue age WM.C.March FH omplications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediata Cause (Finat disaasa or condition resulting in death) eus to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceusa of death? 1 Yae 2 □ No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medicel examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 9-NO 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work?

1 Yes 2 No

1 Cartifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

Physician /Medical Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiera. Important: if item 27 is marked other than "natural, or itema 23a or 28a-f ahow any Injury or other traumatic avont, in the fact of Examiner manths not lifted any injury or other traumatic avont, in the fact of Examiner manths not lifted any injury or other traumatic avont, in the fact of Examiner manths or set any injury or other traumatic avont, in the fact of the fact

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records,

Examiner Physician/Medical by Completed Be 10 Certification:

1 DNaturat

2 Accident

3 Suicide 4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

physician and s the burial-transit certificata be signed by the need has certificata this funeral After Attending death. Hospital or Attandi 24 hours after death Funeral Director: A 24 hours To the F within 2

> State Registrar

edical

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) allegar idson FEB 1 8 2000 2000

5 Pending

Investigation

6 Could not ba

Marcy 32. Registrar's Signature

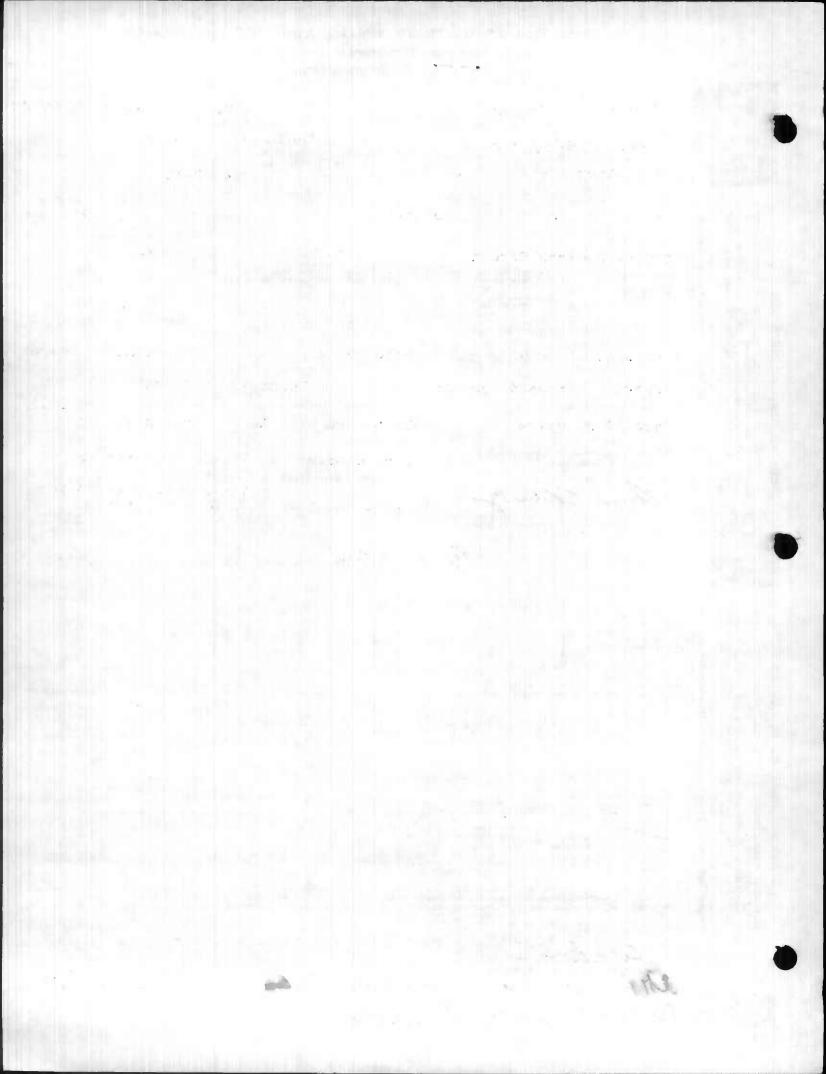
28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

Medical Center 301 St Paul Pl

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

DHMH 16 Rev 6/95



2000 Loomis Maryland

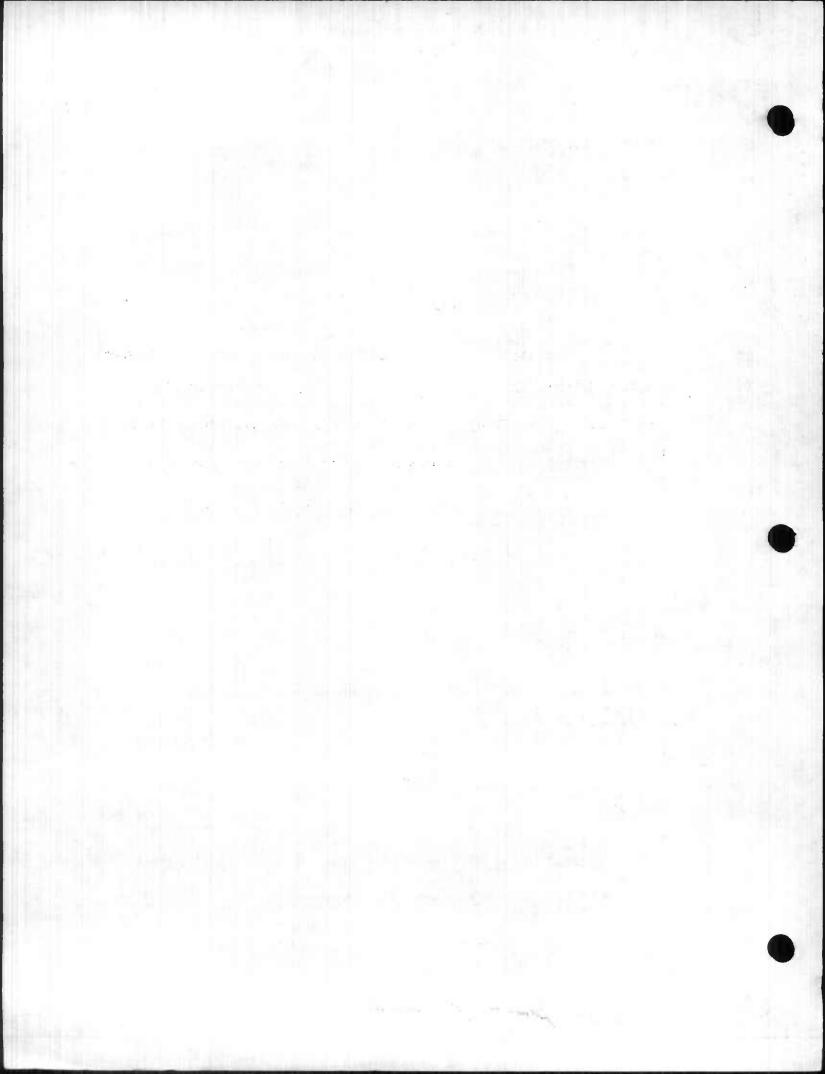
1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey **Physician** ARTHUR V. LOOMIS, JR. FEB. 12, 2000 11:00 A.M. /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OAKCREST CARE CENTER PARKVILLE If Under 24 Hrs. 8. BALTIMORE If Under 1 Year 5. Social Security Number B. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Min. Months Days Hours Director MARYLAND 214-05-3292 83 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Marylan neart of Health and Mental Hygiene. And the man 23a or 28a-f show int: if them 27 is marked other than "natural; or Nema 23a or 28a-f show ury or other traumatic event, are the lice. Examiner mans the motined any 1 Yas 2 No Director BALTIMORE PARKVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8830 WALTHER BLVD. APT. 130 21234 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 14. Rece - American Indian. Black, Whita, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Merried 2 □ Merried 1 Yes 2 No Specify: Specify: þ 3℃ Widowed 4 Divorced WHITE WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) YEAR INSURANCE SALESMAN **INSURANCE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ARTHUR V. LOOMIS, SR. VIRGIL UNAVAILABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other ti BARBARA DUMAS 8445 WATER OAK ROAD FRIEND BALTIMORE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State Department 4 Donation 5 Other (Specify) MORELAND MEMORIAL PARK 2/17/2000 HILLENDALE, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. a ea 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strock, or heert failure. List only one cause on each line. 21286
Approximete
Interval Between
Onset and Death TOWSON, MD **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): physician s the buria Box 68760, Physician/Medical Due to (or as a consequence of): 98 USB P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, δ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? pege 2 s 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 412 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Neturet 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation To the Hospital or American within 24 hours effer death. To the Funeral Director: Afte 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature apt title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OXD 31. Date filed (Month, Day, Year) 32. Registrar's Sig State FEB 1 8 2000 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2.30 AM Raymond. February , 2000 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Villa Nursing Home Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Catonsville Baltimore If Under 1 Yaar It Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthpiaca (State or Foreign Country) 11XM 2□ F Months Days 204-16-7033 Yrs. Director 74 March 13, 1925 PA Usuai Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò or Items 23a 711 Academy Road U.S.A. 21228 12. Was Decedent Ever In U.S. Armed Forcas?

1 □X/es 2 □ No if Yas, Give Yaar or Dates: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 WWII 1 ☐ Yes 2 ☒ No Spacify: White þ 3 ₩ Widowed 4 Divorced natural', Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decadant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) .. Pages 1 end 2 should be fill trent of Health and Mental Hant: If Item 27 is marked off jury or other traumatic even Be John E.Long Bertha Nagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Holly Teal (Daughter) 101 Cherrydell Road, Catonsville, MD 21228 20b. Place of Disposition (Name of cametery, crematory or other place)
Baltimore National 20e. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 2/18/00 Baltimore, Maryland 4 Donation 5 Othar (Spacify) 21. Signature of Funeral Sarvice Licansee 22. Name and Addrass of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Intervai Batween Onset and Death Physician /Medical immediate Cause (Final MYOUARDIAL disaasa or condition resulting in death) Examiner Examiner Arter sician end bunal-transit The law requires that the deeth cartificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in daath) Last Dua to (of as a consequence of): Pertonion P.O. Box 68760, Physiclan/Medical the Due to (or as a consequenca ot): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3□Probably 4□Unknown 1 Yes 2 No signed b Records, þ Completed paga 2 should 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? complation of causa of death? 1 Yes 2 No 1 Yes 219 No Division of Vital tal or Attending Physicien: The star death.

In Director: After this certificated in by the funaral director, p. Be 25. Was casa referred to medical 26. Plage of Death (Check only ona) examiner? Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 Suicide 28e. Ptace of injury - At homa, tarm, street, factory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 ☐ Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated. 29a. Certifian Medical To the Hosp within 24 ho To the Fune complately fi 29b. Signatura and titlerol certifier 29d. Date signed (Month, Day, Year) 29c. License number 0.30469 16. 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) Post of Cott n . 21042 CiTY

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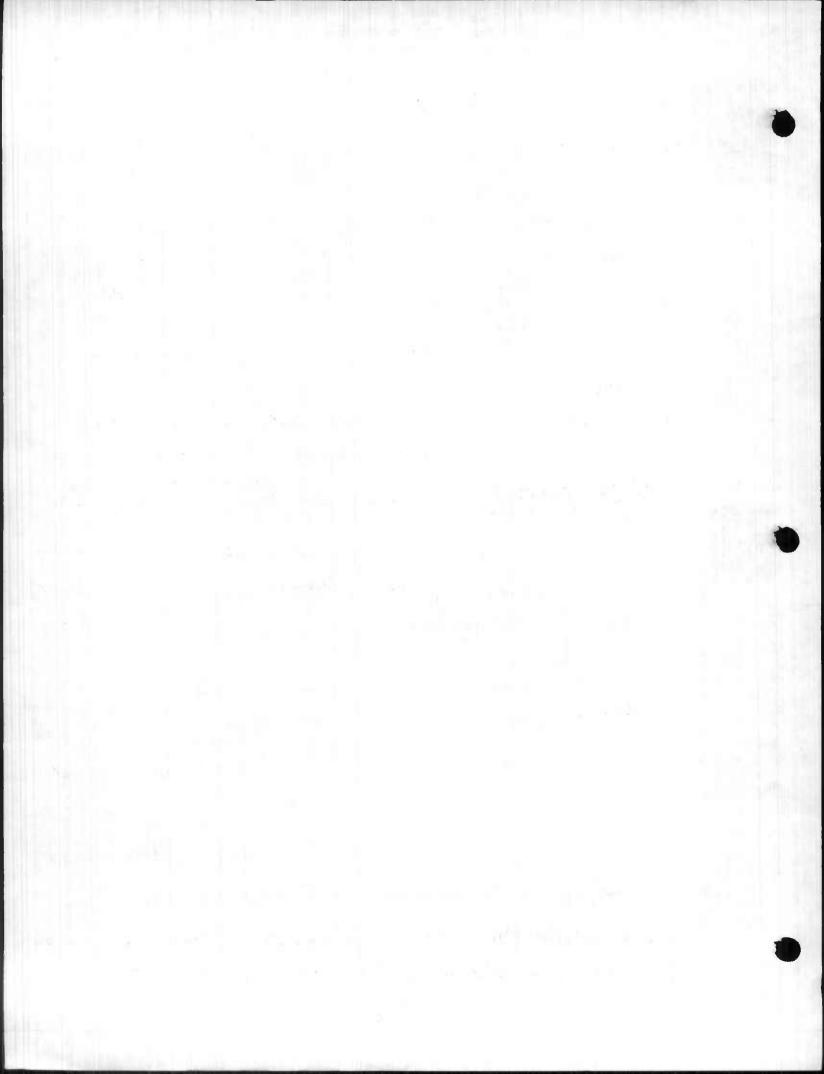
State

Registrar

31. Data tiled (Month, Day, Yaar)

FEB 1 8 2000

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Vaa 8:08 pm LIOR ,2000 15 Ebruary 4a Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death osedale Franklin Hospita Enter Imore guare If Under 24 Hrs. 5. Social Security Number If Under 1 Ye Months Da 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) Days 1□M 2X)F Hours 257-27-8422 28 ISRAEL Usual Residence of Decedent 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6810 CHEROKEE DRIVE 21209 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Elementary/Secondary (0-12) NONE College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) **GEDALYAHU** LIOR MAUREEN LINDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEDALYAHU LIOR / FATHER 6810 CHEROKEE DRIVE - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Crametion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CEMETERY 2/17/00 FINKSBURG, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Immediate Cause (Final disease or condition resulting in death) Weeks neumonia bnor C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yea 200 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 12005 1 Ayas 2 No 2□ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 28b. Time of

The law requires that the death certificeta be executed physician and the burial-trans Box 68766, Physician/Medical 995 P.0. Records, Completed of Vital Physician: B Certification: To the state funeral After Division or Attanding To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Af

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Baltimore, Maryland

filed within 72 hours after death with the Meryland

Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 1 Yes 2000 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1. Skatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1) Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

Square Drive Baltimore

Maryland

State Registrar

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Medical

29b. Signature and title of certifier

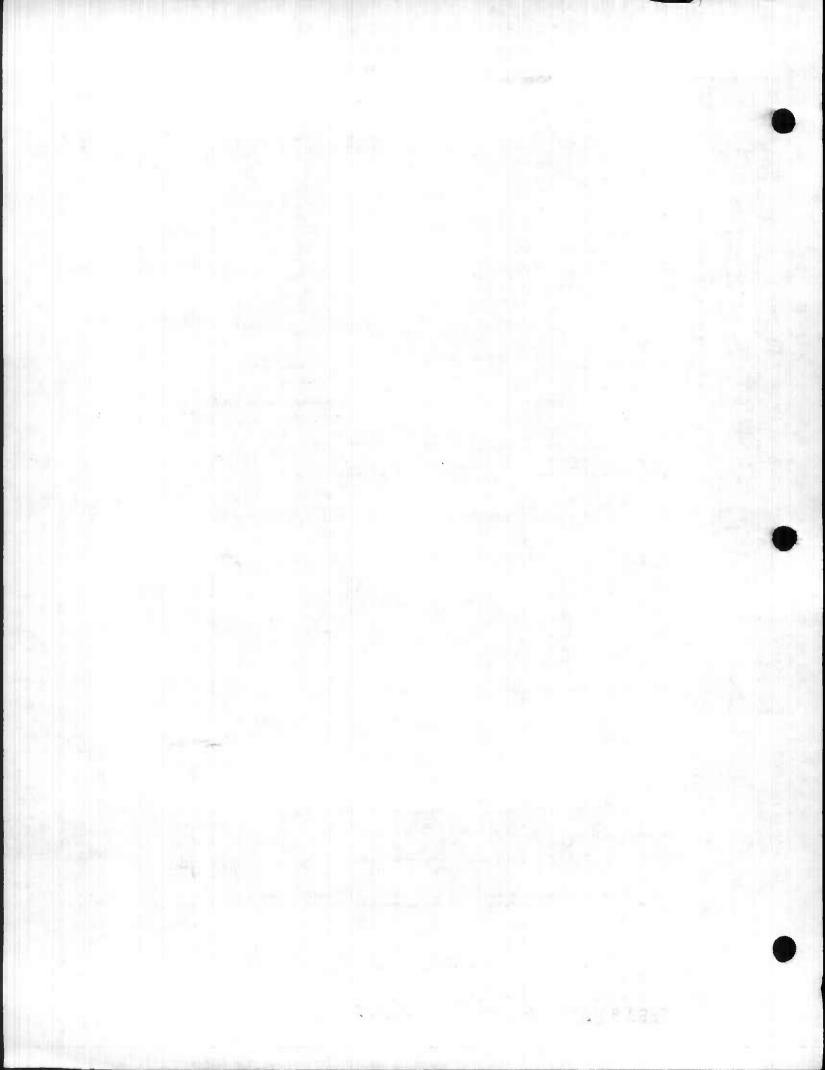
Dr.Michelle

31. Date filed (Month, Day, Year) FEB 1 8 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baswell 9000 Franklin 32. Registrar's Signature

23



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death _Month **Physician** 4:0 AM .06 2000 /Medical 4e. Facility Neme (If not institution, give street end number, 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 7000 Samaritan Balti if Under 24 Hrs. more If Under 1 Year 8. Dete of Birth (Month, Dey, Year) March 20, 1900 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Devs 99 Yrs. Director 219-30-2183 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location IOd. Inside City Limits wode 7 is marked other than "natural", or items 23s or 28s-f shov traumatic event, in Medical Exatranst must be notified at 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5601 Greenhill Avenue 21206 U. S. A. Funerai deeth 12. Wes Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11 Marital Status 72 hours efter 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within: Department of Health and Mentel Hygiene Important: If them 27 is marked other then *n any Injury or other traumatic avant Elementery/Secondery (0-12) 8th Grade College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Frank Kruml Sophia Slechta 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 901 West 38th Street, Baltimore, Maryland 21211 Joseph L. Farroll (Grandson) 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 2 Ovrial 2 □ Cremation 3 □ Removel from State 5 Othe (Special) Baltimore Cemetery 2/16/00 Baltimore, Maryland thre of Fundas Sen 21. Sign 22. Name end Address of Fecility
Schimunek Funeral Home Inc. e Lice 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest,

Approximate

Approximate Approximete Interval Between Onset and Deeth **Physician** 48 his /Medicai Immediate Cause (Final diseese or condition resulting in deeth) Examiner burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest P.O. Box 68760. physician Physician/Medical the Por Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No Records, þ 8 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes an autopsy performed? Deen page 2 1 Yes 2 No certificate 1 Yes 2 No Division of Vital l or Attending Physician: after death. 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) J_o 1 Yes 2 No this funeral 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After 1 Neturel 5 Pending Investigetion 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 \ Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) and menner es stated.

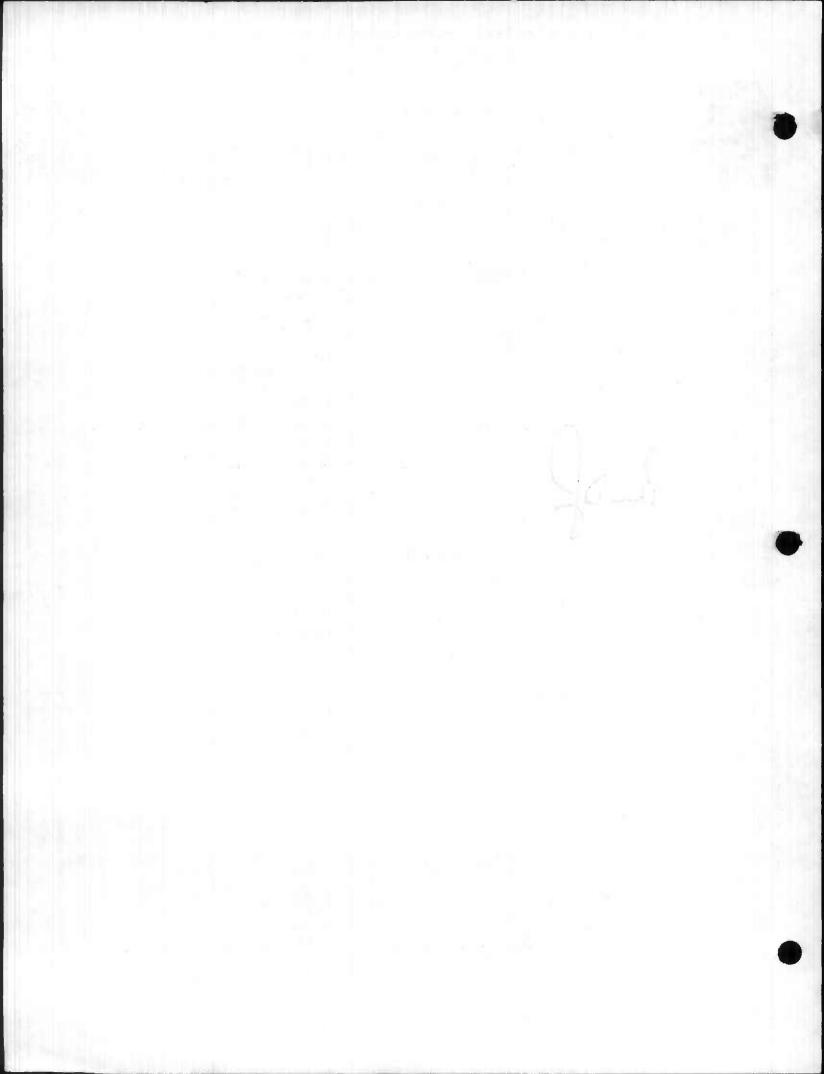
2 Madical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29e. Certifier Medicai completely (Check only one) 29b. Signature end fifte of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) D53642 30. Name end eddress of person who completed Northean Parkway Bultimore 2/214 2404 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture State

DHMH 16 Ray 6/95

Registrar

--- n n ---

FEB 18



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Morris Ihelma 16:45 2000 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore, MD Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1□M 2XF Yrs. Feb. 18, 1922 216-28-4708 Maryland Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f Zip Code 10g Citizen of What Country? 155 N. Decker Avenue 21224 U. S. A. 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 💢 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 N Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Edward Shelley Ida Davis 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Miss Barbara Rich (Daughter) 910 E. Ocean View Ave. Unit 6, Norfolk, VA 23503 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 2/19/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 22. Name and Address of Fecility 21. Signature of Funaral Service Licensee Schimunek Funeral Home Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Maryland 21213 Approximete Intervel Between Onset and Deeth Immediate Cause (Finet disease (orunan 20 Urs artery disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yas 2 No 25. Wes case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after loopartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traumatic avant, the Medical Examples

Saltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

Director

Funeral

by

Completed

Be

2

death with the Maryland

sloian and burial-transit the th

Examiner

Physician/Medical þ Be Completed

Certification: To 27. Manner of Death

that the death certificate be executed signed by the a certificata Attending Physician: this Affer ne Hospital or Attending in 24 hours after death. The Funeral Director: After pietely filled in by the fun

State Registrar

edical Within 24 ho To the Fune completely fi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.R. Gonzalge MO

FEB 18

29b. Signature and title of certifier

5 Pending

investigation

6 ☐ Could not be determined

, MP

Hospitel:

28a. Dete of Injury (Month, Day Year)

Johns Hopkins

32. Registrar's Signature Sanswa

1) Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

medral Center

28c. Injury et Work?

115 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29c. License number

RESODO

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

02/15/2000

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95 9 0

31. Date filed (Month, Day, Year)

1 Yes 2 No

1 Netural

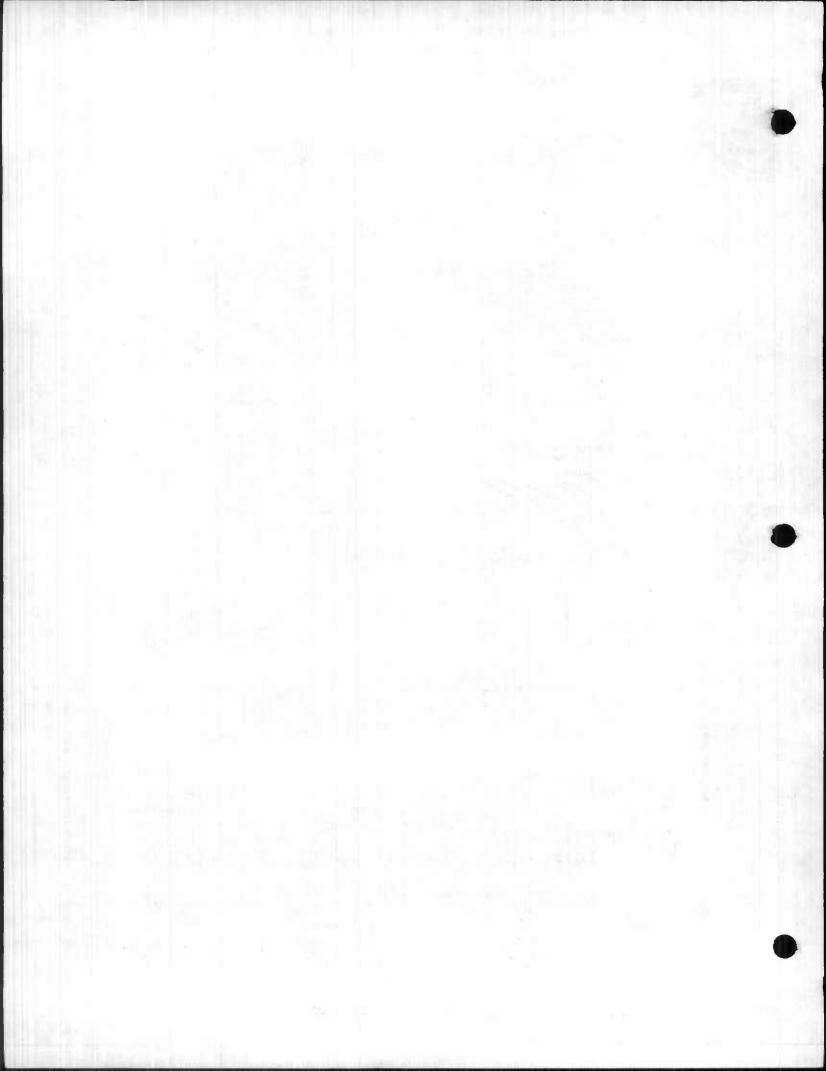
2 Accident

3 Suicide

29e. Certifier

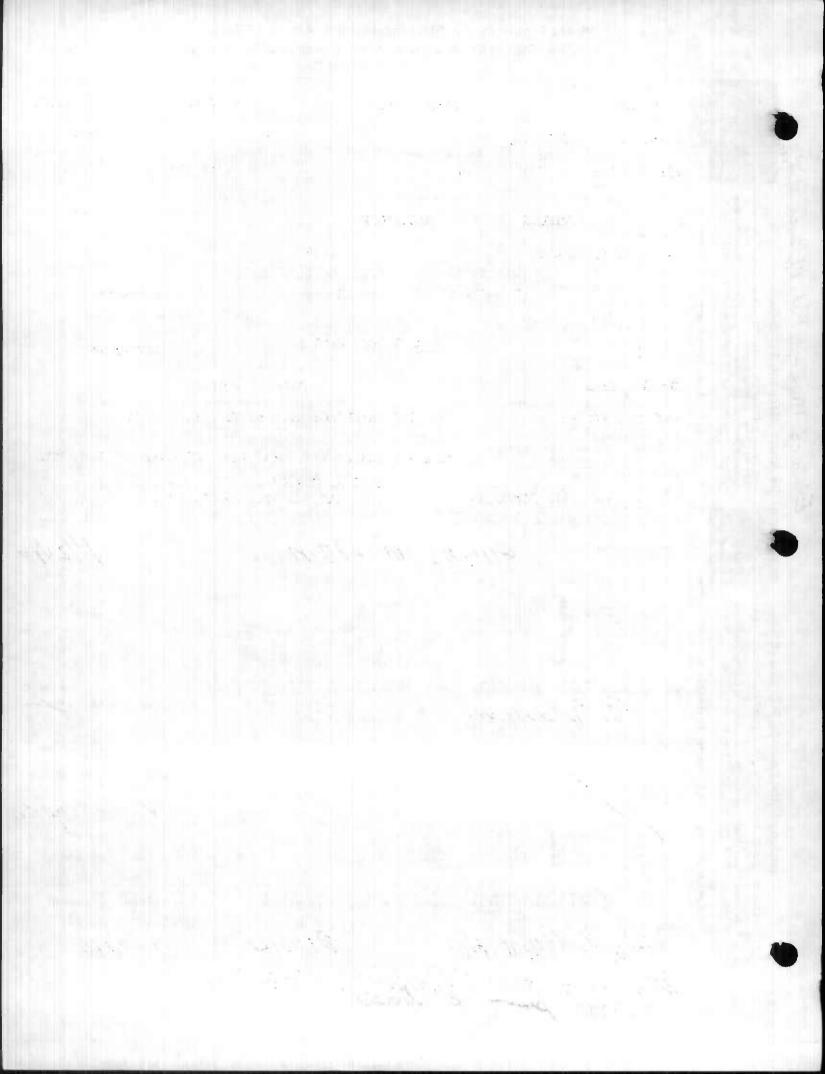
4 Homicide

(Check only



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Certificate of Death Reg. No.										
Physicia:	HIIWARII	2. Data of Death Month Day Yaar 2/17/2000 3. Tima of Death 2:35A.M.									
Examine	4a Facility Nama (If not institution, giv				4b. City, Town, or L		4c. County	of Death	/ .	Ī	
	JOSEPH RICHEY HOS 5. Social Security Number 6. S		land historia.	If Undar 1 Yaar	BA If Undar 24 Hrs.	LTO . B. Data of Birth		O Bidle	N/A		
Funeral Director	251 01 6296	2 F 80	Yrs.	Months Days	Hours Min.	(Month, Day 11/11/	, Year)	Cour	olaca (Stata or Foreign otry) SC		
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or 28	MD BALTIN			10f. Zip Coda		1	log. Citizen of V	Vhat Cour	ntry?		
Marth				212			US				
zaninec	1905 GREENGAGE RI 11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar In U, Armed Forcas? 1 1 1 1 2 2 □ No If Yas, Giva WWII Yaar or Datas:		Was Decedant of H If Yas, specify Cub 1 ☐ Yas XXNo	dispanic Origin? (Si an, Maxican, Puart Specify:	pecify Yas or No- o Rican, atc.)	Blac	ek, Whita, BLAC			
edical Eram		ducation	16a. Dece	dant's Usual Occup	pation	tina	16b. Kind of Bu	ısınass/în	dustry		
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F.			HOW I	IIONO IIAI	,	and Affirmation to the state of		ERNM	ENT		
	17. Father's Name (First, Middla, Last) EDWARD MYERS				ELLA	na (First, Middla, JOYNER		ia)			
other trsumatic event, tre. M	EDWARD MYERS 19a. Informant's Name/Ralationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru			Stata, Zip	Code)		
other trac	MARY MYERS/WIFE		1905	GREENGAG	GE RD. B	ALTIMORE	, MD. 2	1244			
de la	20a. Method of Disposition		lace of Dispo	osition (Nama of matory or other pla	ce)	Data	20c. Location -	City or To	own, Stata	Ī	
ury o	1 ☐ Burlal 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y) GAI	RRISON	FOREST V	VET. CEM	2/24/2000 OWINGS MILLS, MD.					
any Injury or o	22. Nama and Addrass of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD.										
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				24a. Was an autopsy performed? 24b. Wara autopsy findin available prior to completion of cause of death?							
te has						1 🗆 Y	as 20 No	1[□Yas 2□ No		
director, page	25. Was case referred to medical				26. Placa of Dea	ath (Check only or	na)		"		
-	1 Yes 2000	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatler	N 3LI DOA	-	lome 5 ☐ Resid		er (Specia	WHRESPICE	100	
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ral Director: lled in by the	4 Homicide detarmined detarmined building, atc. (Specify)										
To the Funeral Di completely filled in	one) 2 Medical Exam	ysician: To tha best of my kno niner: On tha basis of axaminal and mannar stated.	wledge, daath tion and/or in	h occurred at the til vastigation, in my o	me, date and place opinion, death occu	, and due to tha d rred at the tima, d	ause(s) and ma date and ptace,	annar as s and dua t	stated. o tha cause(s)		
Tol	29b. Signatura and titla of certifiar	June MD.		29c. Licans	130/2		29d. Data signe	d (Month,	Day, Year)		
14	30. Nama and address of person who	completed clause of death, liter	33a) (Type,	Print)	Potto,	2/2/8			NICE,		
State	31. Date filed (Month, Day, Year)	Denter	appa	ing							

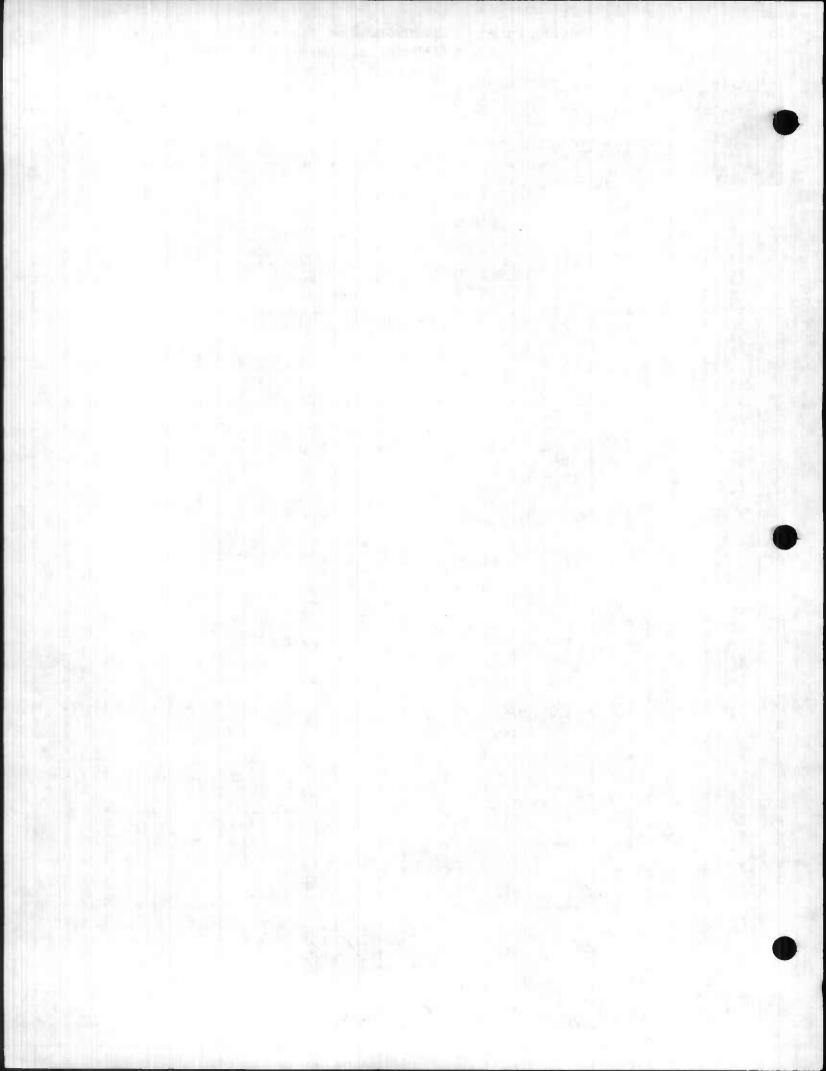


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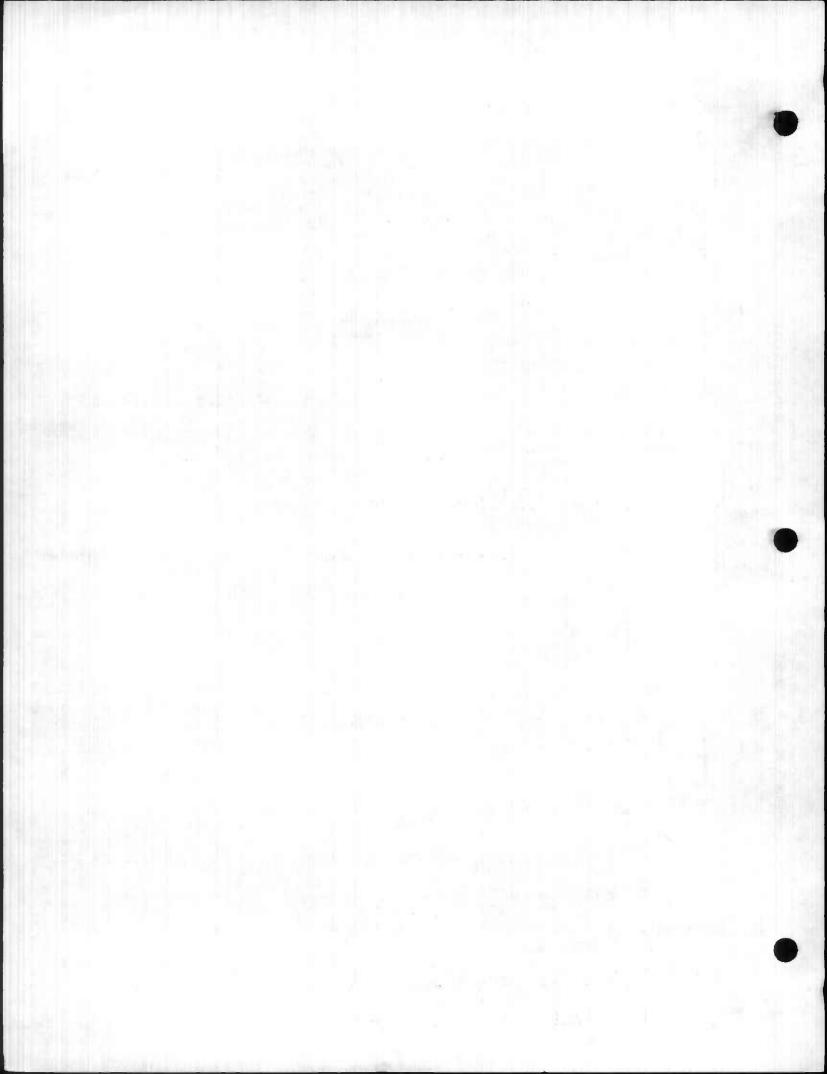
State of Maryland / Department of Health and Mental Hygiene 0 0 4 9 9 4

			C	ertificate of	Death		Reg. No.	04774		
	1. Decedent's Name (First, Middle, L	est)	2. Dete of D		3. Time of Death					
hysician /Medical	Norma J. McCar	tney				Febru	cry 15 . 8	2000 9:36 PM		
miner	4a Facility Name (If not institution, g	ive street and number)			-	wn, or Location of Dea	th 4c. County of	Death	1	
	North Arund	el Hospital		2.4	6 len	Burnie	Anne	Arundel	ı	
ral		Sex 7. Age (In yr.		y) If Under 1 Yeer Months Deys		Min. (Month, D	irth 9ay, Year)	Birthplace (State or Foreign Country)	l	
ector	579-40-7852	1□ M ZXXF 68	Yrs.	1		Oct. 1	.9, 1931 W	ashington, DC	l	
show show ed.at	Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or	Location				10d. Inside City Limits	ł	
								1 ☐ Yes 2 No	ı	
Directo	MD Anne Ar	undel Ga	ambril.						ł	
눔	10e. Street and Number			10f. Zip Code			10g. Citizen of Who	at Country?		
2 2	2268 Time Drive				054		USA		1	
Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 Yes 2 4No	U,S. 13	 Was Decedent of I If Yes, specify Cub 	Hispanic Orig an, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.			
by F	1 ☐ Never Married 2 ☐ Married 30XWidowed 4 ☐ Divorced	1 Yes 214No If Yes, Give Year or Dates:		1 ☐ Yes % No Specify:			Specify:	White	١	
	15. Decedent's E		16a Day	cedent's Usual Occu	nation		16b. Kind of Busin	nose/Industry	1	
Be Completed	(Specify only highest g	rade completed)	(Gi	ve kind of work done DO NOT use retire	during most	of working	100. Killa of Busin	losa moustry	1	
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0 0	Edward Hensell				Ann	a			l	
-	19a. Informant's Name/Relationship	(Type Print)	19b. Ma	iling Address /Stree	-	or or Rural Route Num	ber City or Town. St	ate. Zip Code)	1	
	Rockey G. Willia					ambrills,			l	
	20a. Method of Disposition		Placa of Dis	position (Name of		Date	20c. Location - Ci	ty or Town, State	l	
	1 Burial XIX Cremation 3		-	rematory or other ple rematory	ice)	2000	Baltimor	o MD	l	
	4 □ Donation 5 □ Other (Special Signature of Suneral Service Lice	***		22. Name and Addre	ass of Encilib	1	Daicimor	e, no	ı	
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ledical Examin	resulting in death) Last	/ 50010	000	Co ()	-6	(10-6	/.		Į	
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hys	Part ff. Other eignificant conditions contributing to death but not refuting in the underlying cause given in Part I.						1 Yes 2 No 3 Probably 4 Unknown			
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Ica I	3 Suicide 6 Could not	be Goo Bloom of Injury. At	home farm				(Street and Number	or Rural Route Number,	ı	
T T	4 ☐ Homicide determine	building, etc. (Spec	cify)	on oot, lastory, smoo	100		own, Stete)		l	
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lica		Injection: To the best of my kr iminer: On the basis of examination and manner stated.							1	
200	29b. Signature and title of certifier	ond mainer stated.		29c. Licen	se number		29d. Date signed /	(Month, Day, Year)	1	
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H	Jorge M. Ram.	/	/		C1	n Dijemi -	MD 21061			
	31. Date filed (Month, Day, Year)	32. Registrar's Sign		Lai DIIVE	, Grei	n Burnie,	Z1001		1	
State gistrar	EED 1 R 0000	A. Negistrar's Sig	4	1. ,						
ual	EED * 0 7000	1	11	1100 W. 1	No.					

DHMH 16 Flev 6/95



					Otate of In	arylana,		tificate					Reg. No.		7330
	Dhualaian								2. Dete of De Month	ath Dey	Year	3. Time of Death			
4	Physician , /Medical		William Henry McKenney									February 15, 2000		2:40pm	
, A	Examine		ta Facility Name (If not		11200				4			cation of Deatl	4c. Count	ty of Death	
N.	A LLL		632 Londo							Edge				Arund	
	Funeral Director	5/8-22-/531 'A' 23' 73 Yrs. Oct.						8. Dete of Bir (Month, Da Oct.]	9. Birthpleca (State or Foreign Country) .8,1925 Maryland						
	P	-	Usual Residence of Dec 10a. State 10	b. County		10c. City, To	wn or Loc	cation						1	0d. Inside City Limits
	ath with the Marylar 23a or 28a-f show let be notified at	MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of Wi										1□Yes 2√XNo			
	# 22 E		10e. Street and Number					10f. Zip Co	ode				10g. Citizen of	What Cour	Nry?
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20	72 hours after death with the Maryland netural; or items 23a or 28a-f show deat Eurone Turt to notified		11. Marital Status 1 Never Married		12. Wes Decedent Armed Forces? 1 🖾 Yes 2 🗍 If Yes, Give			Ves Deceden Yes, specify		ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)	- 14. Ra Ble Speci	ice - Americ ack, White,	
8	ural', o	2	3 ☐ Widowed 4 ☐		Year or Dates:	MAMATT									
Maryland 21215-0020	filed within 72 hours afti Hygiene. ther than "natural", or is aft, the Medical Emmi Completed by F	and a	(Specify of Elementary/Secondary	Decedent's Ed inly highest gra ny (0-12)	ucation de completed) College (1-4or :	5+)	16a. Decedent's Usual (Give kind of work life. DO NOT use		ual Occupation ork done during most of working use retired)			ing	16b. Kind of E	dustry	
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and S	2502 0	Ö	17. Father's Name (Firs										, Meiden Sume	me)	
2	should be ind Mental inmertic ever	2	William H	-	-						a Ha				
Ma	01 = = =		19a. Informant's Name/										er, City or Town		Code)
	Health Kam 27 other tr	-	Eloise F. 20a. Method of Disposit		ey (Wife			ondont sition (Name		n Roa	d, E	Dete	20c. Location		Sinto Sinto
Baitimore,	agea ant of rt: If it y or o		· ·	remetion 3 🗆	Removel from State	ceme	tery, crem	etory or other	y plac		ens 0	2/18/			
Bait	pemit. Page Department of Important: If any injury or page.	1	21. Signature of Funeral Service Licensea 22. Name end Address of Facility Hardesty Funeral Home, P.A.												
		+	12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate										Approximete		
P	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.										1	Interval Between Onset end Death		
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s, P.O.			Co	2004	try pri	tery	di	STAR				10	188 2□ No	3 Prof	bebly 4 Unknown
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>	5 00		examiner?		Hospital: 1 Inpatie	ent 2 ER/	Outpatient	3 DOA	Oth	er: 4 Nu	ursing Ho	ma 5 D Resi	dence 6 🗆 O	ther (Specif	(y)
ouo	ath. T: After the funeral a funeral	2	27. Manner of Death 1 2 Natural 5 2 Accident	Pending investigation	(Month, Da	28a. Data of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No						28d. Describe how injury occurred			
Division of Vital Record	tal or Attanding Pris after death. al Director: After to in by the funeral control of the contr		3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Atlanding Phi within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral Medical Certification: 1		29e. Certifier 1 (Check only 2	Certifying Phi Medical Execu	recian: (o the best iner: On the basis of and marther st	disamination a	ge, death and/or inv	occurred at estigation, in	the tim	ne, date en pinion, dea	d piaca, o	end due to the ed at the time,	cause(s) and n date and place	nanner as s , and due to	tated. o the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 0 0 4 9 9 6

						Certificate of	Death	F	Reg. No.		
	4.11		Decedant's Name (First, Middle, Last)					2. Dete of Dea Month	ith Dey	Vaca	3. Time of Death
	Physic /Medi		John Raymond Men	tzer Sr.				0 2		O O	7:50PM
	Exami		4a. Facility Name (If not Institution, giva street	et and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
			Maryland Masonic	Homes				sville		imor	. e
	Funeral Director		5. Social Security Number 2 1 5 - 0 3 - 7 7 1 6 6. Sex	2□ F 7. Aga (In)		hdey) If Undar 1 Yaa Months Deys		8. Date of Birtl (Month, De) 0 6 0	r, Year)		lece (Stete or Foreign try) -yland
	and and		Usual Rasidence of Decedent 10a. Stete 10b. County	10c.	City, Town	or Location				10	Od. Inside City Limits
	Aaryl f sho	ō	Maryland Baltimore			keysville					1 Yas 2 No
	the 28 and 1	Funeral Director	10a. Street and Number		000	10f. Zip Code			10g. Citizan of V	Vhat Coun	itry?
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	death	era	300 International 11. Marital Status 12. \(\)	Vas Dacedant Evar i	n U,S.	13. Wes Decedent of If Yes, specify Cu	1030 Hispanic Origin? (Sp	pecify Yas or No-	14. Rac	USA e - America	an Indien,
Maryland 21215-0020	72 hours after death with the Maryland naturel', or Nerns 23a or 28a-f show deal Examiner must be notified at	by	1 Never Merried 2 Married	Armed Forcas? ☐ Yes 2 ☑ No f Yes, Give Year or Detas:		If Yes, specify Cu		Rican, atc.)	Specify Specify	white, a White	
5-0	be filed within 72 hours ttal Hygiene. d other than "naturel", event, tre Med cal Exa	Completed	15. Decedent's Education (Specify only highest grade controls)	on moleted)	16e.	Decedent's Usual Occi (Give kind of work don life. DO NOT use retir	upation	kina	16b. Kind of Bu	sinass/Ind	Justry
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12	filed within Hygiene.		07	N/A		ottle Shop	1		Nation		ewery
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Į,			shock, or heart failure. List only one or	use on each line.	eath. Don	of enter the mode of dy	ring, such es cardiac	or raspiratory an	rast,	l I	Approximate Interval Between Onsat and Deeth
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L. Jacobs Joseph y dript NAME OF STREET OF STREET, ASS. ASS.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Maude 1:40AM Murph February 14 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimac City N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Director 212-76-9263 88 Sept. 24,1911 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Pinewood Road 21222 United States Funeral Hems ? 14. Race - American Indien, 11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married 8 1 Yes 2 No Specify: by Specify 3 2 Widowed 4 □ Divorced Year or Dates "netural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. then Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home other ent of Health and Mental Hy t: If Item 27 le marked 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be William Herbert Turner Winifred Foote Harrell 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Upperfield Ct. Kingsville, MD 21087 Mr. Marvin A. Murphy (Son) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 8 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Pege Department of Important: If eny Injury or once. Oak Lawn Cemetery 2/16/00 4 Donetion 5 Other (Specify) Baltimore, Maryland 22. Neme end Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of unerel Service Licensee Caro 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease) or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaf failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Mellucuis disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical the Due to (or as e consequence of): USB signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably WUnknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 904 2 No 1 ☐ Yes 2 ☐ No 1 Yes funaral director, 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To MInpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Neturel 5 Pending 1 Yes 2 No To the Hospital or Attendir within 24 hours effer death. To the Funeral Director: Al investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one)

or Attending Physician: The law requires that the death certificate be asscuted

Box 68760.

Division of Vital Records, P.O.

filed within 72 hours after death with the Maryland

21215-0020

Baltimore, Maryland

Peges 1 and 2 should

State Registrar

DHMH 16 Rev 6/95

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29b. Signeture and title of certifier

31. Data filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHNS HOPKINS BAYVIEW MEDICAL CLUTER 4940 EASTERN AVENUE MANYKING 21224 32. Registrer's Signeture

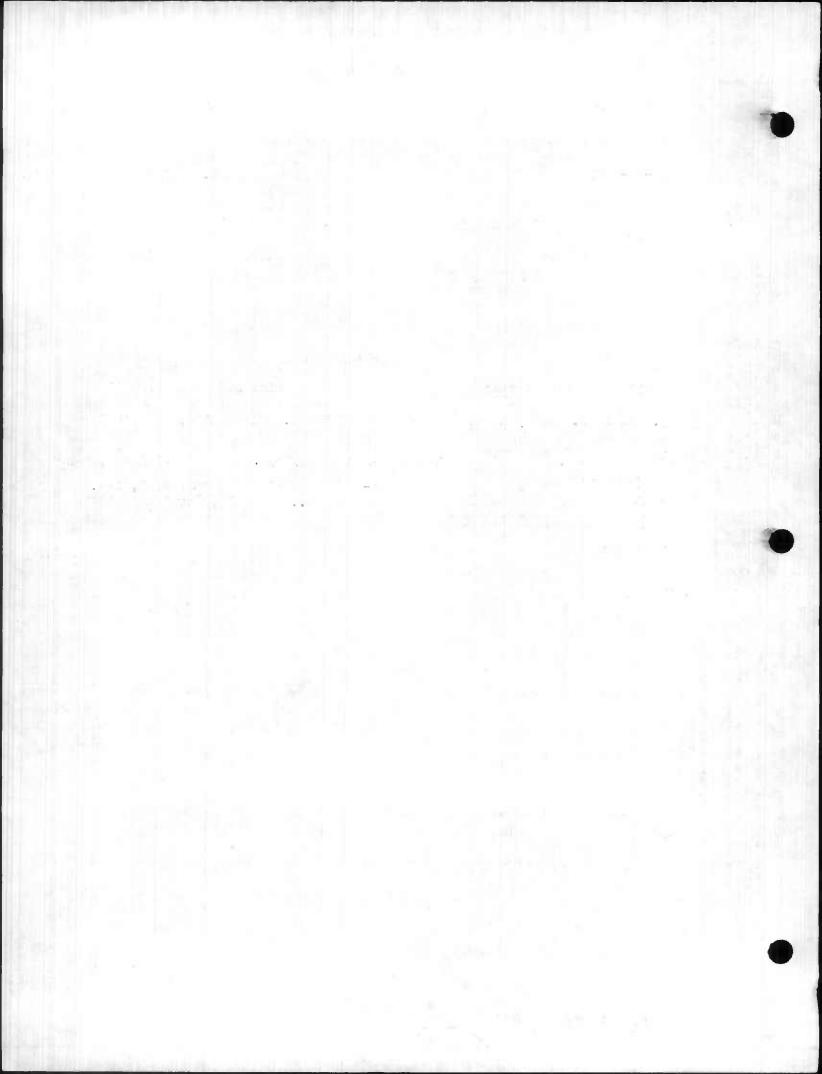
M. Sugmour, MD lukern

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29d. Dete signed (Month, Day, Year)

February 14,2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 20 b per fh 2/18/00 G780 ya 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** therine lae Ke 2000 /Medical Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hills! P.O. BOX 50 Orsica If Under 1 Year Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1 ■ M 2 F 214-14-4184 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore risust be notified at MD 1 Yas 205No Director Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 1 Baldwin Court Apt J 21228 IISA items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Dacedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner filed within 72 hours after 1 ☐ Never Married 2 ☐ Married ò by 1 ☐ Yes 2 BNo Specify: Specify: White 3. Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) d 2 should be filed within the and Mental Hygiene. 7 Is marked other than "t Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward W. Byrnes Mabel Rodgers Pages 1 and 2 should 19a, Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Nem 27 is any Injury or other trau 1 Baldwin Ct. Apt, Roger Rew/son J. Balto, Md. 21228 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 02 14 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, 736 Edmondson Avenue, Balto, Md, ase, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, is only one cause on each line. Approximata Interval Between Onset end Death Physician /Medical Immediete Cause (Final Dementer 5110VS disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai the Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by þ 9 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peen completion of ceuse of death? 1 Yes 2 No 1 Yas 2 PNo certificate director, Be 25. Was cese referred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 26a. Dete of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Investigation 1 Deturel 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Records, Division of Vital or Attending Physician:

21215-0020

Maryland

Baltimore,

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun.

State Registrar

Q

Medicai

31. Date filed (Month, Day, Year)

3 Suicide

29a, Certifier

4 Homicide

29b. Signatura and titla of certifiar

6 Could not be

29c. Licensa number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end menner es steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steled. 29d. Date signed (Month, Day, Year)

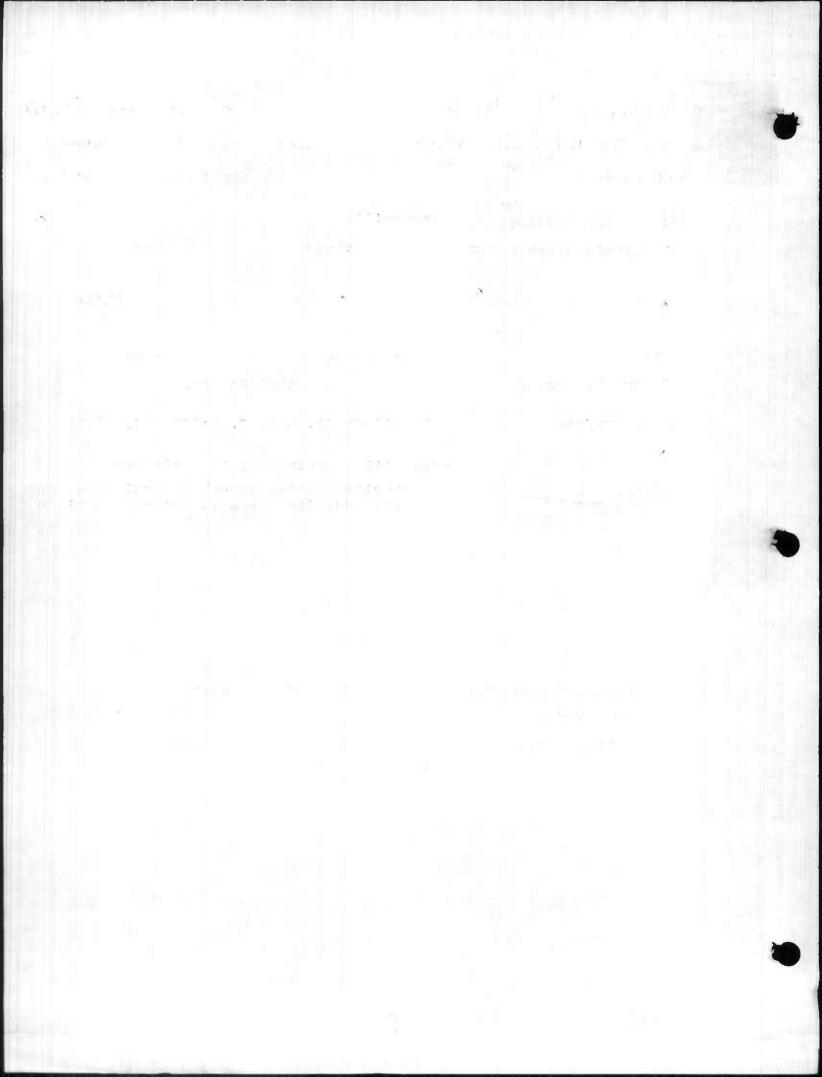
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) KUSSELL A

2540 Contreville Po

Schilling DO /

FEB1 8 2000

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death February 15, 2000 **Physician** Betty S. Nims 8:15AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Charlestown Care Center Baltimore Catonsville If Under 24 Hrs. # Under 1 Year 8. Date of Birth (Month, Day, Year) May 17, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 10M 2QF 213-18-0132 Yrs Pennsylvania Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1□ Yes 2HNo MD Baltimore Director Catonsville 288-7 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? Barns 23s or 717 Maiden Choice Lane ST 603 21228 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Merried à Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nant of Health and Mental Hygiene. Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) å marked Clifton F. Schmidt Lotta E. Fingal 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ä important: If Itam 27 any Injury or other tr Albert Nims (Husband) 717 Maiden Choice Lane ST603, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Balto-Washington Crem. 4 Donation 5 Other (Specify) 2/16/00 Laurel, Maryland 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical tmmediata Cause (Final MDENOCARCINOMA disease or condition resulting in death) Examiner Examiner ettending physicien and for use es the burlel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco usa contribute to the cause of death? Yaa 2 No 3 Probably 4 Unknown ONCESTIVE WEART Records, p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? i certificate has b 1 Yes 2 No 1 ☐ Yes 2 R No Division of Vital Hospital or Attending Physicien: 24 hours effer death.
Funeral Director: After this certifica tiely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 413 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 BNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a, Certifier Æ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 1.0 BRUPAM 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

MAIDEN

31. Date filed (Month, Day, Year)

FEB 1 8 2000

CHOICE

LANE

32. Registrar's Signature

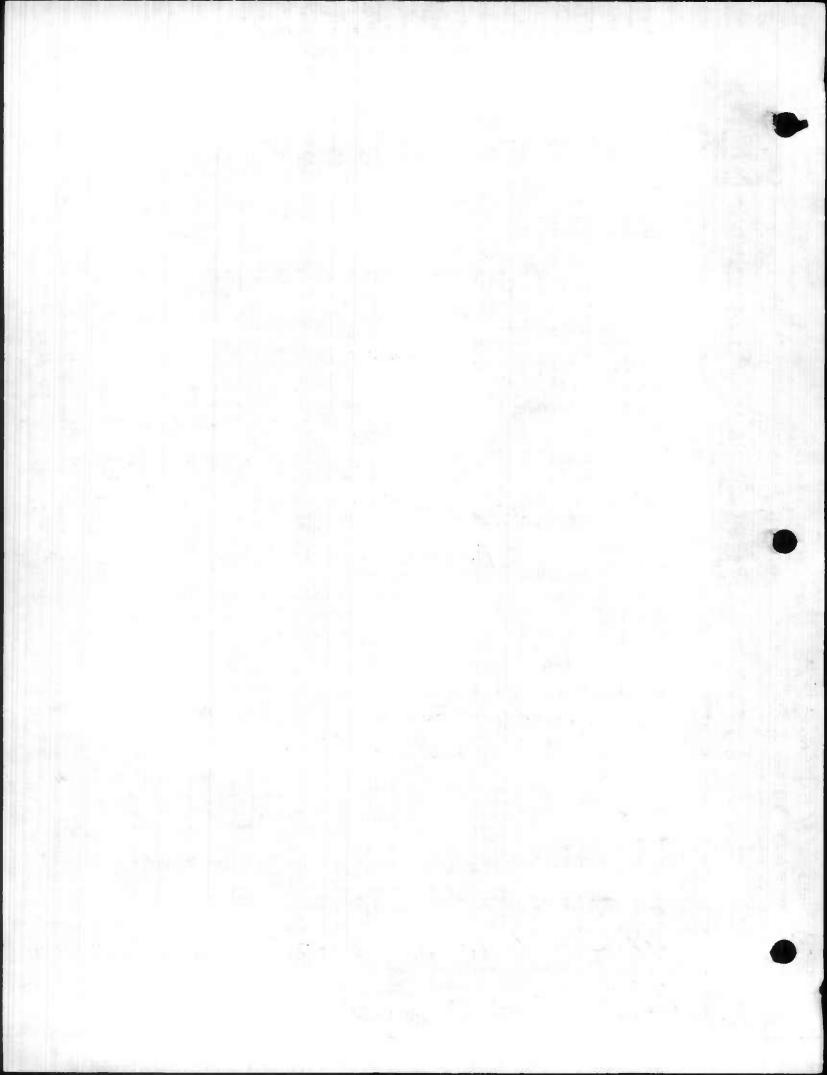
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21228



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** TYRONE H. PLANTER February 12 , and a find of Death (14c. County of Death 4:52 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Yeer If Under 24 Hrs. Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1⊠M 2□ F Yrs Director 214-40-9323 56 2-28-43 MD, Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits show 1 ♥ Yes 2 No MD. N/A BALTIMORE Director 288-1 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö 23a 347 E. 27th ST 21218 Funeral USA Buns 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiens, and of Health States and Mental Hygiens, and if them 27 is marked other than "natural, or its uny or other trainmate event, the Medical Examines ury or other trainmate event, the Medical Examines ☐ Yes 2 No f Yes, Give 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK ğ 3 ☐ Widowed 4 € Divorced Year or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) -12--0-MAINTENANCE STATE 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 HARRISON PLANTER HELEN BRYANT 19a, Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) SHARITA PLANTER (DAUGHTER) Department of Health Important: If Item 27 1827 W. FAYETTE ST. BALTIMORE, MARYLAND 21223 20b. Piece of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cametery, cremetory or other plece) 1X Buriel 2 Gremetion 3 Removel from Stete 4 □ Donetion & □ Other (Specify) ZION CEMETERY 2-17-2000 BALTIMORE, MARYLAND 21. Signetum of Funerel Service Libe 22. Name end Address of Fecility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Fiter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel Mypoxia disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner Preumonia 6 weeks The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of): and Box 68760, Physician/Medical the Due to (or as e consequença of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 3 □ Probably 4 ☑ Unknown 2 1 Yaa 2 No Records, by should be d Completed 24b. Were autopsy findings available prior to 24a. Wes en autopsy parformed? completion of cause of death? page 2 certificate Division of Vital or Attending Physician: funeral director. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Meturel 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 Homicide Filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier yeleter 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) February 12, 2000 201 E. University 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PKWY Baltimore, MD E. Lewis 10 Union Memoria Hospital 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Ray 6/95

Registrar

FEB 1 8 2000